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CONTENTS:

CLINICAL LECTURES.

- STOCKTON, DR. CHARLES G., Buffalo, N. Y.—Pediculosis.—ANASARCA..... 189
PEPPER, WILLIAM, M. D., Philadelphia, Pa.—Hodgkin's Disease.—Duodenal Ulcer..... 192

COMMUNICATIONS.

- PRINCE, A. E. M. D., Jacksonville, Ill.—Trachoma and the Tin Wash-basin..... 195
MILLIKIN, DAN, M. D., Cincinnati, O.—Diphtheria of the Genitalia..... 197
COTTON, JOHN C., M. D., Meadville, Pa.—Pelvic Peritonitis Resulting in Cystic Degeneration of the Ovaries and Tubes; Removal; Death from General Peritonitis on the Fourth Day..... 197
BALDY, DR. J. M., Philadelphia, Pa.—Vaginal Cysts..... 199
CREMATION..... 201

FOREIGN CORRESPONDENCE.

- Letter from Paris.—Prophylactic Measures against Tuberculosis.—Tracheal Injection of Naphthol in Pneumonia.—Ocular Complications of Influenza.—Removal of all the Bones of the Face for Osteo-fibroma due to Misplaced Teeth.—Treatment of Urinary Fistulae Consecutive to Nephrotomy..... 203

PERISCOPE.

- Antipyretics in High Fever.—Syphilis of the Spinal Cord.—Etiology and Treatment of Blepharospasm.—Contagious Pneumonia.—Salpingotomy in Cases of Closed Utero-Vaginal Canal.—Hair Wash.—Lactation during Menstruation.—

- Mouth-Breathing and the Teeth.—A Leech in the Larynx.—Menthol in Acute Rhinitis, and other Affections of the Throat and Nose..... 206-210

EDITORIALS.

- ASYLUM ABUSES..... 211
HYPERTROPHIC ULCERS OF THE VULVA..... 212
DANGERS OF CELLULOID..... 213
TYPHUS FEVER AT NEW YORK..... 214

BOOK REVIEWS.

- HALL; Student Aids Series..... 214

LITERARY NOTES.

- 214

CORRESPONDENCE.

- Inversion of Uterus.—The Porro-Cesarean Operation..... 214-215

NOTES AND COMMENTS.

- Long Fastings and Starvation.—Total Resection of Facial Bones.—Dobell's Solution.—Fatal Alcoholic Poisoning.—Plaster of Paris Splints.—Preservation of Urine for Examination.—The Prophylaxis of Tuberculosis.—Mind Blindness.—U. S. Army Examining Board.—Extra-Uterine Pregnancy.—Alvarenga Prize.—Paralysis from Compression of the Wrist.—Treatment of Angina Pectoris.—Treatment of Gonorrhoea in the Female.—Antipyrin Incompatible with Naphthol..... 216-226

- NEWS..... 220

CLINICAL LECTURES.

PEDICULOSIS.—ANASARCA.¹

BY DR. CHARLES G. STOCKTON,
BUFFALO, N. Y.

Pediculosis.

Here is a patient who has spots of marked pigmentation all over his body. Wherever he has been able to reach he has scratched himself, and the continued scratching has given rise to the pigmentation. This is a very good example of pediculosis corporis. There are three forms of pediculosis: that which affects the scalp, that which infests the body, and that which is found in the hairy parts of the body other than the scalp. The three forms of the pediculosis are known as the head-louse, the body-louse, and the crab-louse; and

they seem to be distinct. The ova of the head-louse are deposited along the roots of the hair of the scalp, where they germinate. The pediculus corporis is found only on the body. It does not burrow into the skin, but draws blood from the body through a kind of proboscis. It sucks blood so greedily that its color is changed in the act from a yellowish white to a yellowish red. This insect is two or three millimeters long, has six hairy legs and a long, sharp snout. When the clothing is removed, nothing is found on the body, because the animal has retreated into the seams of the garments. In this, the pediculus corporis differs from the head-louse and the crab-louse. This last is found in the hair of the pubes or arm-pits, or sometimes in the hair over the sternum or even in the eyebrows.

You can recognize pediculosis by the mottled eruptions and particularly the scratch-marks. The diagnosis is confirmed by searching the garments. The cure for

¹ Delivered at the Buffalo General Hospital.

this disease is cleanliness. It is not sufficient merely to take a bath and put on the same old clothes again; these must be got rid of or boiled, preferably in an antiseptic solution. Then use some soothing application for the skin.

Anasarca.

This man came before you a week ago, when we had the opportunity of studying him from the standpoint of anemia. His anemia came about largely from the loss of albumin and also from interference with nutrition by indigestion and malassimilation due to the disease from which he suffers.

He has been sick seven years. He took cold and had pain in the back, his feet and then his whole body became swollen. Two years later, he began to have persistent headache and occasional dizziness. His eyesight became so indistinct that he could not count his own fingers; it is now much clearer. His appetite is capricious, and his bowels usually constipated. He feels better when his bowels are open and when he sweats. His urine is irregular in quantity.

He is pale and has a muddy skin. A clear sclerotic is usually a sign of health; if it is pearly it suggests tuberculosis. In this case it is somewhat jaundiced. The man's tongue is pale, a little tremulous, covered with a thin yellowish-white coat, which seems to involve the epithelium, but is not very closely attached to the tongue itself. When I first felt his pulse, I made the snap diagnosis that he had a kidney lesion, and that he was passing a large quantity of urine with not much albumin but with hyaline and granular casts. I was right, except in saying that he passed uniformly a large amount of water; for it is sometimes large, sometimes small. What was it about his pulse that led me to think he had kidney disease? He had the "whip-cord" artery, so that a continuous ridge could be felt along the radial vessel, and that indicated a thickening of the vessel walls. It was not compressible in the sense that the ridge could be made to disappear, though the blood could be pressed out of the artery. I knew that we had a case of endarteritis, involving the intima, perhaps the media, and possibly the adventitia. The pulse was a *pulsus tardus*, a slow, dragging pulse of high arterial tension. The one thing that is most likely to produce both these conditions is a certain form of kidney disease, and so I flew to my

diagnosis and I came pretty near being right.

The man is 27 years old, a laborer, and married; he has always been temperate, has used tobacco to some extent, never had gravel nor scarlet fever, and was never sick before this disease.

On inspection of the body, we notice the same muddy skin. The abdomen is prominent, and we get the ascitic wave. There is a certain amount of oedema of the back, feet, and legs, and the nutrition of the skin is depressed, as it always is after oedema. The skin is rough, and there are lines of tension, it is a little like fish-skin. When the bowels are regular, the patient tells us, the feet are smaller; when they are constipated, the feet become larger.

We have to do, then, with a case of general anasarca which includes the ascites, the dropsy of the legs, feet, and back, and the oedema under the eyes and about the temples which he formerly had. Notice the relation between the bowels, skin, and kidneys. The kidneys are not able to carry off the fluids of the body as they should, and, therefore, a certain amount of labor must be taken from them by the bowels and skin. When the bowels and skin lend themselves to this task, the fluids are carried off and the man feels well. When they are not able to work, not only water but urea and ten thousand other things, some of which we know and some of which we do not know, accumulate in the body. Remember, it is not merely urea that is present when we say there is uremic poisoning. Most of the essential oils, arsenic and other metals and alkaloids, are carried off in the urine. The alkaloids produced in the body are normally so disposed of, and if they accumulate we have signs of poisoning such as headache, faintness, dizziness, vomiting, and a peculiar malaise and weakness which occur in the history of Bright's disease.

Let us study the relation between the arteries, the heart, and the kidneys. In Bright's disease we may have an exudation of serum into the abdomen, the pericardium, the pleural cavities, often into the scrotum and the tissues of the prepuce, and sometimes between the meninges of the brain. This last is necessarily rare because of the usual upright position of the patient. We will examine to see if he has fluid in any of the great cavities of the body besides the peritoneum. The apex-beat of the heart is on a vertical line with the nipple and two

inches below the left nipple. One of two ment or an heart is enlarged ventricle for the apical position were enlarged so that the clearly only visible apex not appearing border of with the s and I hear tensity. I accentuation heart to the at the left moderate there is an from the i rent and th sion, we ha valves on a of the blood and sound in the stude more mark sternum, I ing up of the left aur ventricle, w of the clos valves.

Here we high tension as the result made by indicates there was have more We might ing to char in the blood ciency we lower angl thence to t bruit in the a slight m murmur.

It was lo disease the trouble, pa trophy, an come on w after it.

inches below it. Thus, the apex is carried to the left, and this must be the result of one of two things, either a lateral displacement or an enlargement of the heart. If the heart is enlarged at all, I judge that the left ventricle must be the one that is enlarged, for the apex-beat is heard clearly in its normal position, whereas, if the right ventricle were enlarged, it would lap over this place so that the first-heard sound would be heard clearly only at the extreme left edge of the visible apex-beat. Moreover, the heart does not appear to extend much beyond the right border of the sternum. I hear a murmur with the systole of the heart at the apex, and I hear it nowhere else with so great intensity. I also hear a remarkably intense accentuation of the second sound of the heart to the right of the sternum; whereas, at the left intercostal space, there is only a moderate accentuation. This signifies that there is an enlarged, left ventricle, and that from the increased force of the blood-current and the consequent rise of arterial tension, we have a forcible closing of the aortic valves on account of the powerful back flow of the blood. This accentuation of the second sound is one of the most important signs in the study of heart disease. If it were more marked along the left border of the sternum, I would say it was due to the backing up of blood from the left ventricle into the left auricle, and from that into the right ventricle, which would cause an accentuation of the closure of the pulmonary semilunar valves.

Here we have diseased arteries, a pulse of high tension, a strongly-beating heart, and, as the result, an accentuation of the sound made by the aortic valves. The murmur indicates a slight mitral insufficiency. If there was greater insufficiency, we would have more marked pulmonary enlargement. We might consider it a hemic murmur owing to changes in the walls of the heart and in the blood. If it is a real mitral insufficiency we ought to hear it behind at the lower angle of the scapula and extending thence to the spine. I can hear a very faint bruit in the back and I think we have here a slight mitral insufficiency and not a hemic murmur.

It was long ago noticed that with Bright's disease there was usually coincident heart trouble, particularly left ventricular hypertrophy, and this was sometimes found to come on with the kidney lesion, sometimes after it. Several theories have been ad-

vanced to explain this. The earlier theory was that following the disease of the kidney there was an inability on the part of the kidney to get rid of the fluids of the body, because some of the tubules were plugged up from the parenchymatous changes in the kidney. Therefore, the healthy tubules would have to do more than their share of the work, and, in order to do so, there must be a greater blood-pressure. Because of this long-continued increased blood-pressure, the left ventricle must hypertrophy. The thickening of the arteries has been explained by the chemical theory, an inflammation having been set up by the poisons circulating in the blood. I have no doubt that this theory holds good in a certain proportion of cases.

There were found to be, however, a class of cases characterized by the passage of a very large quantity of urine early in the disease, which continued for a long time, and with this there was increased arterial tension and left ventricular hypertrophy, and Drs. Gull and Sutton, of England, brought out the theory that this was due to a general arterial change throughout the body—an arterio-capillary fibrosis consisting of an increase in the amount of fibrous structure in the heart, the vessels of the body, and of the kidney. Thus, they said, certain areas of the kidney would be robbed of their blood-supply, there would be atrophy of certain cells of the kidney, and a cirrhotic kidney would result. In this condition, there would be not only a cirrhotic kidney but a cirrhotic heart and blood-vessels. Thus they believed that this cirrhotic kidney was quite distinct from other forms of Bright's disease.

DaCosta and Longstreth of Philadelphia have found that there were accompanying disturbances of the sympathetic nerves. The sympathetics involved were those that presided over the blood-supply and nutrition of the kidney. I have no doubt that, as the result of these disturbances, we have the fibroid changes in the vessels.

This is not a typical case of arterio-capillary fibrosis, because it followed exposure, and the amount of urine is variable. In arterio-capillary fibrosis the vascular tension is great, and hence a large amount of urine is evacuated, and with only a little albumin and few casts. In this case we have a considerable quantity of albumin and hyaline casts, and particularly granular casts, which show degeneration of the specific kidney epithelium. We have to do with a mixed

case of Bright's disease which has probably begun in the parenchyma and extended to the stroma. It is a chronic diffuse nephritis. This condition is often the result of the alcohol habit, but not in this case. Sometimes it comes from long-continued exposure to cold, or from blood-dyscrasias such as rheumatism, gout and lithemia. It may be due to the extension of pyelitis and other forms of nephritis, such as acute nephritis following scarlatina and other infectious diseases. It may follow a cyanotic kidney, itself the result of a previously existing heart disease. There are also a variety of other causes. He gives the history only of taking cold while sweating. Probably he had the disease before he knew it, and the cold made it worse. One of the most common causes is the uric acid diathesis, especially in those who are gouty or lithemic.

Following his kidney lesion came the change in the heart, and then in the arteries. Then albumin appeared and granular casts. At times you will find blood and epithelial casts earlier in the disease.

The dizziness, headache and disturbance of vision must be considered. Hemorrhages in the retina and changes in the optic disc occur early in fibroid kidney, and hence the use of the ophthalmoscope is important. Since the vessels may become plugged up, or capillary aneurisms form which may rupture, there is danger of apoplexy. The dizziness and headache are due to imperfect blood-supply to the brain. If a capillary aneurism ruptures in the brain, a sudden and short-lived attack of paralysis may result and others may follow.

Naturally when we find very high arterial tension, we feel like reducing it, and I have done so here but without good results. I gave him nitro-glycerin, which reduced the amount of urine, because it lowered the blood-pressure. It has, therefore, been discontinued. Usually, nature will increase the blood-pressure to the proper extent in this form of Bright's disease, though she will not in others, and if you raise the already high tension you will increase the strain upon the heart and vessels which are already weakened, and sometimes your patient may have an attack of apoplexy. Occasionally, however, it is necessary to give digitalis to increase the blood-pressure and consequently the elimination of waste substances by the kidney. In some cases the indication may be to lower the blood-pressure. Keep the bowels and skin active, usually

let the blood-pressure alone, observe proper hygienic precautions. This man shall be given Basham's mixture, shall be kept in bed constantly and the greatest attention paid to his digestion. His diet shall be modified according to the amount of albumin lost and the quantity of urea eliminated. He shall have a steam-bath in bed twice a day.

HODGKIN'S DISEASE. — DUODENAL ULCER.¹

BY WILLIAM PEPPER, M. D.,

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Hodgkin's Disease.

Gentlemen: This man is 45 years old; his family history is bad. Personally, he has always had good health until two years ago, when he had a sunstroke, from the effects of which he never fully recovered. Over one year ago he noticed that his belly was commencing to swell. This was attended with a loss of flesh and strength, but without any pain. There have been no evidences of fever. He is quite anemic. We have here a very bad history. On making a physical examination I elicit the following facts: In the first place I notice an immense enlargement of the abdomen, which is not entirely symmetrical. It gives no sense of fluctuation on palpation. I find that it is irregular in outline as determined by percussion. Above the growth there is a marked tympany associated with a succussion splash, due to a dilated stomach. To the right is a deep-seated intestinal resonance with something dense between it and my finger. The liver is in its normal position. Although there is dulness from the ribs down to the mass, I do not think that it grows from the liver, for Dr. Stillwell, who has kindly brought in this patient to-day, tells me that the lump was first detected lower down and has grown in an upward direction. On palpating over the abdomen I find an immense hard mass, nodulated, of an irregularly rounded form with nodules sticking out from it in every direction. It is superficial in position, but extends deeply into the ab-

¹ Delivered at the Hospital of the University of Pennsylvania.

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dominal cavity. By placing my hands on the sides, I am able to raise it a little. It has, therefore, a slight degree of mobility, and is not painful on ordinary pressure. The spleen I can feel to be enlarged materially. It is three times as large as normal, but is not connected with the mass. The glands of the groin are very decidedly enlarged on both sides. There is a trifling enlargement of the glands at the left angle of the jaw, and in the axillæ a marked enlargement of the glands.

Now, what is this tumor, and to what is it attached? It is a solid mass with no fluctuation at any point. An examination of the blood shows no leukemia. The red blood corpuscles are normal in size, but paler than in health. Their number has not been counted as yet. The two diseases which come to my mind at once are lymphatic or pseudo-leukemia and carcinoma. It is one of these. Now, as against the notion of carcinoma we have found that there is comparatively little pain and that there is a wide-spread affection of the lymphatic glands. This enlargement is too symmetrical and evenly distributed to be like secondary carcinoma, but is very like that occurring in lymphatic leukemia or in pseudo-leukemia. Still, I would not say that it could not be carcinoma, but that it is excessively rare for carcinoma to produce a condition like this. It is not a case of leukemia, but I believe it to be a very marked case of pseudo-leukemia. In both of these conditions the red blood corpuscles are greatly reduced in number, but in pseudo-leukemia the white corpuscles are not considerably increased in number. The evidence, then, is in favor of Hodgkin's disease—lymphatic pseudo-leukemia. This tumor I believe to be an implication of the omentum and superficial mesenteric glands. I do not believe that the deep glands are involved, or there would be pain from pressure upon the deep nerves. Pending the completion of the examination of the blood, I shall diagnose this condition as Hodgkin's disease of an extraordinary variety.

Perhaps the strongest argument in favor of this being a case of carcinoma would be found in the apparent hereditary history which this man presents, both of phthisis and carcinoma. His father died of consumption at the age of 45. One sister died of throat consumption. Another sister has disease of the spine. One brother died of a lump in the left side of his chest, probably carcinomatous. Now Hodgkin's disease has

no hereditary character whatever, while carcinoma has a strong hereditary character. Then, again, Hodgkin's disease is very rare, but such a case of primary lymphatic sarcoma is just as rare, if not rarer. Still the argument from rarity is one of the most fallacious to us living in such a community as we do—that is, the American people, for a clinic like this is a sieve through which everything passes, and we do not wish to jump at the conclusion that we have found something rare which could be explained in a more simple manner. The prognosis in either event is most unfavorable, and the disease is one rather of diagnostic interest than of practical value, and it is one of the opprobria of the profession that it should be so. However, as yet everything has been tried to influence the progress of this destructive change in these deep lymphatic tissues without success.

Hodgkin's Disease.

This man was brought here by Dr. Morton, and is 54 years old. He is a farmer resident in Bucks County. His mother died of old age. His father died of an obscure abdominal tumor. The other members of his family are hearty. He was always sallow and a little pale as a young man. Twenty years ago he had an attack of intermittent fever. Six years ago he began to notice that the glands on the left side of his neck had commenced to enlarge, and soon there was a mass of tumor there. The axillary glands of the right side next developed. The front of his chest then became covered with a network of distended veins. His liver and spleen were normal on examination. A dark yellow, nearly brownish pigment appeared in spots over his body. He takes cold easily, and at times suffers from attacks of neuralgia in his head. He becomes short of breath on the slightest exertion. The condition of his blood is as follows: on the ninth of February last the red corpuscles numbered 3,900,000 and the hemoglobin 75 per cent.; the urine was normal. On the nineteenth of October red corpuscles had increased to 4,500,000; the hemoglobin 65 per cent.; the urine was normal.

Let us study this case in the light of the one just before us. The surface of his chest is covered with scars due to an old acne. I find a mass of glands under the left angle of the jaw, hard, movable, painless, with no discoloration of the skin, and

no adhesions to the surrounding parts. On the right side is the duplicate of this. There is symmetrical enlargement of the axillary glands, and to a smaller extent of the inguinal glands, just about as much as in the other case. The spleen is not at all enlarged, and the liver is normal. There is no enlargement of the abdominal glands. The veins at the root of the neck are greatly distended, and this, together with the fact that he complains of shortness of breath, seems to indicate that there is an enlargement of the intra-thoracic glands. The heart is normal, and there is no abnormal substernal dulness. There is an area of dulness at the right side of the sternum extending from the second interspace to the fourth which is very probably due to a cluster of enlarged glands at this point. This man has been treated in the orthodox way with increasing doses of Fowler's solution, beginning with three drops and increasing to fifteen drops three times a day, together with the proto-carbonate of iron three to six grains three times daily. Under this treatment he has decidedly improved. The number of his red corpuscles has increased, and there has been no further enlargement of the glands. Why should this be? The case presents all the appearances of Hodgkin's disease, and yet it is improving. It is a case of the first interest, and should be watched carefully. In both of these patients the use of Fowler's solution and the proto-carbonate of iron will be continued and pushed to tolerance.

The man I now show you is the case of splenic leukemia which you saw last Saturday. He looks bright to-day. We are keeping an exact record of the state of his blood, noting the changes which take place in the leucocytes from day to day. At present the proportion of leucocytes is one to four, and his red corpuscles are down to two million. An important question which now arises in connection with these three cases is, Why, in one case, do we find a diminution in the number of the red corpuscles with a large increase in the number of the leucocytes, while in the other there is the same diminution in the red with no increase of the leucocytes? What is the difference between the two conditions? This we cannot answer. There is a connecting link which we have not yet made out, but it has been noticed that at times a case of Hodgkin's disease will, towards the close, turn into true leukemia. There are then transitional

stages of these conditions, and the connecting link must be studied.

Duodenal Ulcer.

This man is 44 years old. Two years ago he was perfectly healthy, although he has served in the army. At that time he commenced losing flesh and strength, and complained of pain in his belly upon the right side with soreness on pressure. This continued until fifteen months ago when he suddenly vomited a large quantity of blood, and also passed a considerable quantity from his bowels. This was repeated several times, and then stopped until a short time ago, when it recurred again. At no time has he had nausea. When he has the hemorrhage it comes up copiously. He has marked dyspepsia, meat and vegetables causing diarrhoea and pain. His bowels are irregular; the stools often green and slimy. He often has night-sweats, and frequently becomes bilious. He has been accustomed to the free use of undiluted whiskey. Now, what are these symptoms due to? You notice he has an attack of hematemesis associated with melæna following the free use of alcohol. He has had severe gastro-intestinal catarrh for two years or more. To explain this condition two diseases occur to me, and the diagnosis rests between them. One is cirrhosis of the liver, and the other is an ulcer. He has used liquor all his life pretty freely. Cirrhosis of the liver has, for its most common cause, the excessive use of undiluted spirits. This will also inflame the glandular apparatus of the stomach, lead to degeneration of the coats of the stomach with the production of gastric catarrh. This change extends to the liver and produces a chronic inflammation there. The history of cirrhosis is that the liver first enlarges, and then as the disease progresses it becomes hard and shrinks to smaller than normal. In examining here in the axillary line as well as the nipple line I find that the liver is not changed. This fact, as well as the absence of enlargement of the abdominal veins leads me to think the man has not cirrhosis of the liver. He has had, however, a long continuance of pain. This is not a symptom of cirrhosis, but is of ulcer of the stomach. On the whole I think this man has had an ulcer, whether of the stomach or duodenum I cannot say, since both will produce vomiting and purging of blood. Gastric ulcer is so much more common than duodenal ulcer that we give the preference

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to that, but vomiting is a prominent symptom of that condition. There has been none in this case, so I will prefer to regard this as a case of duodenal ulcer.

As regards treatment, the man must be kept in bed, counter-irritants used, a restricted milk-diet given, and nitrate of silver administered in the form of a pill. His only chance for recovery is the absolute stoppage of the use of all alcohol, otherwise he will be very apt to die during another hemorrhage.

COMMUNICATIONS.

TRACHOMA AND THE TIN WASH-BASIN.¹

BY A. E. PRINCE, M. D.,
JACKSONVILLE, ILL.

In choosing the relation existing between trachoma and the tin wash-basin, as the title of this brief paper, it is with an earnest appreciation of the importance of the subject it embraces. The communicability and prevention of this disease is a sufficiently serious question to command the attention of the thoughtful sanitary student. There are diseases of the eye which are more fatal, and there are others which are more painful, but in the number of individuals affected, and the serious and lasting consequences of its course and complications trachoma outstrips them all, if not the sum of all, in the misery and discomfort it entails. One has but to spend a few weeks in any one of the large dispensaries for the treatment of the diseases of the eye, and see the ratio that these multitudes bear to all others, the distressing complications of corneal ulcers, pannus, prolapse of the iris and opacities; the indelible effects on the conjunctiva; atresia, symblepharon, lachrymal stenosis, erosion, and the deformities of the lid; plepharophimosis, entropion, trichiasis—and he must be convinced that the prevention of these calamities is worthy of serious attention.

We are taught that Salter isolated and cultivated the diplococcus of trachoma, but

heretofore insufficient attention has been devoted to the elucidation of the media and avenues by which these micro-organisms are conveyed from one eye to another. In Egypt the same disease, known as Egyptian ophthalmia, is regarded as the pest of the country and the calamity of the race. Both there and in Syria it is the exception to the rule if one escapes the disease. The most plausible explanation of the degree of communicability in these dry and sandy countries is found in the absence of surface water, in consequence of which the flies quench their thirst by lighting on the face and drinking the moisture from the margins of the lids. In this way from one individual to another the germs of trachoma are conveyed. Sometimes it is said, by those who have investigated the subject, that a bleary-eyed beggar may often be seen with a ring of flies perched about either eye waiting to carry a load of infection to more healthy sources of moisture.

With such causes as these added to those arising from the prevailing habits of filth and negligence, it is not strange that trachoma should be regarded among the inevitables and little effort be made to arrest or quarantine it. But in Northern countries the case is different. General moisture prevails and the medium of flies falls out of the account. Here the disease is found almost limited to one class, viz., the indiscriminate washing class.

For the past ten years I have been compiling statistics, and was not a little surprised two years ago to find that 80 per cent. of all my trachoma cases are furnished by the male portion of the farming population. This surprising fact led me to institute an investigation to ascertain the assignable, and ultimately the true source of contagion. In every case I have attempted to trace the disease to the pre-existing disease in another individual. Frequently I have been unable to do so, but usually if the disease has been of recent origin the patient has been able to recall the knowledge of some one who had sore eyes and used the family wash-basin, an accompaniment of almost every farm-house. So intimate was found the connection between the disease in question and this omnipresent basin that I began (at first in jest, but, with experience, more seriously) to assign as the cause of every new case which appeared, the "back-door tin wash-basin." Sometimes it would appear on investigation that the assumption was partly wrong. It

¹ Read at the Fourteenth Semi-Annual Meeting of the District Medical Society of Central Illinois, Nov. 12, 1889.

might have been the side-door, it may not have been tin, but it was the invariable family basin which served alike for friend and stranger. In one case it was strongly held for several weeks that the disease originated from a beard of wheat, which entered the eye while threshing. The patient was requested to make particular inquiry at the different places at which he had recently been, previous to the outbreak of the attack, and upon his next visit he confessed to have found the source at the last place at which he had been engaged, in the person of the owner of the farm, who had had sore eyes for many years.

There is probably no one here who has not had abundant experience to enable him to testify as to the universality of this condemnable practice of the farmer, which is followed entirely through ignorance of the risk it entails. In one case it has been possible to trace the course of a harvest hand about the country by means of the number of those who sought treatment for trachoma, and whose infection could be traced to this one origin.

In passing, I should not wish to be accused of injustice by omitting mention of the claims which may rightfully be urged in favor of the accompanying roller-towel. The partnership is a strong one and is doubtless often a boon to the unfortunate microbe. Burdened by the inhospitality of cicatrization and medication, he severs his ancestral ties, embarks with his family in the drop of muco-pus, survives the maelstrom of the wash-basin, and finds shelter and protection in the friendly meshes of the towel, from which his family are safely landed in an Eden of fertility, where, freed from persecution, he commences with renewed vigor to sow the seed of future generations. The intimate association between the towel and basin render it impossible to decide in any individual case to which to attach the blame, hence we cannot do otherwise than indict them both. The sticky smear of soap and dirt which adheres to these basins for days, and eludes ordinary efforts of cleansing, forms a surface well calculated to become the source of infection; while the dangers of the towel are more apparent to the average individual. If the latter is more dangerous, the former is at least more treacherous.

That the same habits of indiscriminate washing prevail in the towns, and especially among the poorer classes who live in small

quarters, there can be no doubt. The habits of the country enable us with less uncertainty to trace the thread of evidence; but wherever the disease exists, it may usually be traced to some one individual.

But this is not the age of communism, and until that era arrives it becomes our duty to inculcate ideas of cleanliness, the ameliorating influence of which will be proportionate to the extent of their dissemination.

Some years ago the Institution for the Education of the Deaf and Dumb in Jacksonville was much tormented by the annual development of trachoma. It was found that the male and female pupils had each a place where water and towels were common property. Attempts to quarantine had been a failure, because often the healthiest outside appearance conceals the latent trachoma follicles, which, in a new soil, may manifest its most angry forms. The basin gave place to streams of running water, individualism in the possession of towels was established, and the few cases which gained entrance into the school of five hundred pupils, drawn from every sphere of life, found scant media for communication, and trouble in this direction ceased.

We may find a seeming parallel in the comparison of notions with regard to the matter of cleanliness and the presence of trachoma. It is a singular fact that Switzerland is almost devoid of trachoma. In Berne, Professor Pflüger, who has charge of an extensive eye clinic, told me that he had had but two trachoma cases in the hospital during his experience, and they were imported. Professor Haab, of Zurich, complained to me that they did not have enough trachoma to familiarize the student with its natural history. Neither of these professors was able to assign any reason for this immunity; and in the absence of a better explanation, it may be regarded as a result of the universal cleanliness which seems to pervade the life of this little republic. The large and small towns, side streets and back-doors all give evidence of the military discipline which during the centuries has implanted sanitary precautions and personal cleanliness in the life and habits of the people. At the other extreme stands Ireland, with a maximum of trachoma, and a population devoid of the instincts of cleanliness. The conclusion is difficult to escape, that the relation is intimate and that Utopian discrimination in washing would lead to the extermination of the disease.

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DIPHTHERIA OF THE GENITALIA.

BY DAN MILLIKIN, M. D.,

PROFESSOR OF MATERIA MEDICA AND THERAPEUTICS, MIAMI MEDICAL COLLEGE, CINCINNATI, O.

It needs not many words to tell all that is known of diphtheria of the genitals. Few of the large systematic treatises on the practice of medicine make any reference to the disease seated in the genitalia. It is not pretended by any author that the disease as exhibited in or on the penis or vulva or vagina has anything distinctive about it. The membrane has the ordinary composition of fibrinous matter derived from the patient, and the bacteria is more or less essential for the disease.

Diphtheria can develop itself on any mucous membrane that is not too remote from the air. It is not a month since I saw a case of pharyngeal diphtheria wherein the little patient announced the arrival of the disease by a convulsion, and in this convulsion he bit his tongue. The little wound of the tongue developed a membrane before it could be perceived in the pharynx, and it remained there until the death of the child from toxemia, although the pharynx became clean as the child sank lower and lower.

Many observers have noted the development of the disease on the common integument where it has been denuded of its external layer by vesication or by mechanical means.

It is not uncommon behind the ears of children, and it takes root freely at the angles of the mouth and at the palpebral angles where the skin, merging into mucous membrane, is poorly nourished and is liable to ulceration and abrasion. So that in the nature of things it is not to be wondered at that the genitals are often the seat of diphtheria. There, upon the penis and vulva, as at the angles of the mouth and eyelids, the skin and mucous membrane merging into each other and the hands of the patient are instinctively busy carrying the poison from the mouth, perhaps, to these parts.

Diphtheria affects the penis most frequently at the base of the corona, and there is no doubt that when this region is kept moist and tender by a neat-fitting prepuce its vulnerability is greater. Repeatedly circumcision wounds have been the seat of diphtheria, and in some cases there has been

reason to suspect that the child has been inoculated from the mouth of the operator.

Vaginal diphtheria has been observed not in little girls alone but in puerperal women. In child-bed it is especially liable to terminate in general sepsis. In such cases the uterus and appendages are highly inflamed, but it has not yet been made out with certainty that the disease travels so far: in other words, the inflammation of the deeper organs may bring on the inflammation of general puerperal sepsis—not of diphtheria.

It is doubtful whether diphtheria ever passes beyond the male urethra into the bladder. Jacobi gives account of a case in which the bladder was completely lined with a membrane which passed for a diphtheritic membrane. The catheter would not penetrate it, and at the autopsy it was found to be a complete sack full of urine. But the suspicion arises that this was not a specific product of diphtheria, but a simple inflammation of the interior of the bladder with abundant fibrinous exudation.

There is simply nothing to be said of the treatment of such diseases. Whatever general or local treatment may be indicated for diphtheria of the pharynx is indicated here. We are not to suppose that the fact that the disease has developed of the genitalia is a fact of any great significance unless, possibly, it indicates that the patient furnishes an unusually congenial soil for the development of the disease.

PELVIC PERITONITIS RESULTING
IN CYSTIC DEGENERATION OF
THE OVARIES AND TUBES; RE-
MOVAL; DEATH FROM GEN-
ERAL PERITONITIS ON
THE FOURTH DAY.

BY JOHN C. COTTON, M. D.,
MEADVILLE, PA.

Believing that good may be accomplished by a report of failures as well as successes, a history of the following case is submitted.

The patient, Mrs. L., 29 years old, married, and the mother of three living children, inherited a scorbutic diathesis, her mother having died with consumption, also one sister. Her personal history being in some respects unique, merits brief mention. Married at the age of 16, she bore three children in rapid succession. In the fourth pregnancy, in 1883, she aborted at two

months, after which she was attacked with acute general endometritis, which gradually subsided but later was followed by chronic inflammation of the uterus and its appendages. After protracted rest in the recumbent position and energetic treatment she slowly recovered, a slight tenderness in pelvic region and uneasiness in left iliac being the only symptoms not entirely relieved.

In the spring of 1885 a typhoid pneumonia confined her to her bed for quite three months, from which she finally recovered with almost a complete loss of resonance in apex of the right lung, which remained in that condition ever afterward. In the following spring she fell from a step-ladder and dislocated the coccyx from the sacrum. She was then confined to the recumbent position for five or six weeks in the hope that union would take place, but was finally compelled to submit to the operation for removal of the coccyx.

In the fall of the same year she was subjected to a tedious confinement in bed from a second attack of endometritis which extended and involved the pelvic peritoneum. This attack was quite severe, but after about the same course of treatment as had been previously adopted she partially recovered, but the distress in the pelvis which had continued since the former attack was more decided, especially in the left ovarian region.

Pregnancy once more occurred early in 1887, during which there was some amelioration of the painful pelvic symptoms. After the birth of a delicate child that only survived a few months, the pelvic pains were aggravated and extended to the right side. In Jan., 1888, pregnancy again took place, and she once more aborted at two months, after which she became a confirmed invalid, being confined to her home almost all of the time and much of it to her bed ever afterward. The prominent symptoms were extreme pain in the region of the ovaries and tenderness throughout the pelvis.

Every known line of treatment was honestly tried, including electricity, protracted rest, hot vaginal douches, persistently used, for months, the patient recumbent, a succession of blisters, large and small, but without permanent relief. Dr. W. D. Hamaker, of Meadville, and Dr. Geo. E. Benninghoff, of Bradford, were at different times called in consultation and an operation for a laceration of the cervix was at one time decided upon and performed with the expect-

tation that it would have a beneficial effect on the sub-involution of the uterus, which still persisted, and the pelvic distress. The relief, however, was confined to the former, no appreciable benefit resulted in the latter.

As a last resort and at the patient's request, who declared that she preferred death itself to such continual sufferings, an operation was decided upon, with the hope of giving relief, as well as to determine the real pathological condition of the uterine appendages. In the forcible language of Tait, "absolute accuracy of diagnosis within the pelvis is very far from being possible; only the ignorant assert that it is and only fools wait for it."

At the City Hospital of Meadville, Oct. 4, in the presence of Drs. Hamaker, Hassler, Calvin and Carmichael, all of Meadville, under rigid aseptic precautions, the operating room having been thoroughly fumigated, an exploratory incision two inches in length was made. The left ovary and tube were readily hooked up by the index and brought into view as there were only slight adhesions. Many transparent cysts larger than peas were discovered imbedded in the surface of the ovary and several were found in the whole length of the tube. The ovary itself fluctuated. Under such circumstances and taking account of the previous suffering and the evident present hyperesthesia in that locality the indication seemed plain for their removal. For this purpose the incision was extended to three inches, and the parts being well exposed a strong double silk ligature was applied to the pedicle as near the uterus as possible. A pressure forceps was applied to the included structures close to the ligature and the appendages shaved off along the blade of the forceps.

The right ovary and tube were found to contain cysts also of a similar character, although not so numerous as those on the left side. This ovary fluctuated also. These were removed in the same manner as the left had been.

There was not more than an ounce of blood lost and no untoward circumstance occurred during the operation. The cavity of the abdomen being dry before it was closed a drainage-tube was not deemed necessary. The incision was closed in the usual manner by four silk sutures to the inch, entering the peritoneal surface fully one-third of an inch from the line of incision and emerging on the cutaneous surface near the edge, to prevent puckering.

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Iodoform was dusted on the wound and iodoform lint applied. Large rolls of sterilized absorbent cotton then followed, held in position by adhesive plaster, the whole enveloped by a binder. The patient was then placed in bed with strong confidence in her recovery, especially when compared with other more difficult and apparently less promising cases successfully operated on in this hospital within the last few years. She was not excessively emaciated and her strength was fair notwithstanding her long confinement.

The patient rallied well from the shock and the temperature was but slightly above normal during the first day but on the morning of the second day severe pain was experienced in the abdomen and the temperature rose to $102\frac{3}{4}^{\circ}$. On the third day all the symptoms were aggravated, the bowels became decidedly tympanitic and $\frac{3}{8}$ gr. morphia hypodermically were required every fourth hour to allay the suffering. The temperature was now $105\frac{3}{4}^{\circ}$. Death ensued on the morning of the fourth day or seventy hours after the operation.

The ovaries at a subsequent examination were found to be not much enlarged but were true cysts and each was filled with about a drachm of fluid of the same character as that contained in the small cysts heretofore described.

The appearance of the cysts and the ovaries in this cases is well illustrated in vol. II, *American System of Gynecology* by engraving fig. 299 in Coe's article, "Diseases of the Ovaries."

VAGINAL CYSTS.

BY DR. J. M. BALDY,
PHILADELPHIA, PA.

On July 18, 1889, Kate D. consulted me for what she considered "falling of the womb." She was 35 years old, married, and had had one child seven years before. Immediately after her labor the "lump" had appeared, but her doctor told her it would soon go back. In spite of this assurance, however, the condition had remained the same, causing her great discomfort and at times incapacitating her for her work. She had always been forced to push it back before micturition. During the past seven

years she has been under constant treatment by different physicians for rectocele and cystocele, tampons and pessaries being the favorite treatment.

On examination, the parts showed what at first sight appeared to be a simple prolapse of the bladder and uterus. On attempting to push this back into the vagina a sensation of too great thickness of the anterior vaginal wall was conveyed to the finger and a slight further investigation disclosed the fact that there was probably a cyst present. A sound in the bladder together with the finger in the vagina, demonstrated a soft fluctuating tumor and easily settled the diagnosis. The cyst occupied the anterior part of the vaginal vault, extending antero-posteriorly from about the neck of the bladder to within an inch of the cervix uteri; it was almost exactly in the median line and did not reach the lateral sulci on either side. The cyst was a single one about the size of a small hen's egg and was sessile. The mucous membrane covering it was in all respects like that of the surrounding parts, being of the character so commonly seen in these old cases of prolapse, where the parts have been exposed for years: it slid back and forth over the cyst with great readiness. The cyst did not seem to have grown any for the seven years of its probable existence, or, rather after it was discovered as a supposed cystocele, nor did it interfere (further than a partial prolapse would) with coition. The tumor was removed by enucleation on the following day. The edges of the mucous membrane were trimmed away and brought together by a row of interrupted sutures. Several strands of catgut were placed at the bottom of the wound, lying its whole length and protruding at each end as a drain. The wound healed well, excepting the first two stitches, which were torn out by the nurse while using the syringe. This point healed by granulation. The perineum and cervix need repairing, but the woman has not yet returned for the second operation. These cysts are very curious and many theories have been propounded to explain their origin.

1. That they are simply the result of an accumulation of the secreted fluid in a depression formed by the union of the crests of two contiguous folds of mucous membrane.

2. That they are the result of simple dilatation of the lymph channels which

traverse the connective tissue of the vaginal wall.

3. That they owe their origin to the ducts of Gärtner.

4. That they owe their origin to the glands in the vaginal mucous membrane.

It hardly seems worth while to look for such unlikely sources as the first two. We have mucous membrane and lymph channels in other parts of the body, where we do not have cysts forming to the same extent as here. This reasoning will hold especially good, as both the last two sources seem so probable and so analogous to what happens in other parts of the body; and until some more definite proof, that even a single case has so arisen is produced, I shall have to look for simpler means of explanation. From the fact that the ducts of Gärtner are situated in this part of the body, it becomes a great temptation to put these down as the source of origin. This is, in fact, done by many authorities, but I think without sufficient cause. In the first place, there has been no real anatomical evidence offered that such is a fact. In the *American Journal of Obstetrics*, for Nov., 1887, Johnston argued for this point, and reported a case of which he said, "we believe that the cysts in this, our own case, originated in a dilatation of the vaginal portion of the right Gärtner's canal." He fails, however, to produce the slightest corroborative evidence. In his case there were three or four cysts, each one containing a different kind of fluid, which would hardly have occurred had they all originated from the same duct.

These ducts of Gärtner lie towards the sides of the vagina and if the cysts were formed from them, they would all be attached, more or less, to the lateral walls. This, however, is not true, as they occur most frequently on the anterior and posterior walls of the vagina, and about equally so on each. Therefore, I think we must look for some other source; this would seem to be the vaginal glands. "The mechanism of cyst-formation in these glands is like that of retention cysts in secreting cavities elsewhere," and with this simple explanation of their existence I can see no reason for trying to find some more complex source. The one difficulty with this explanation is the fact the very existence of vaginal glands has been denied; but with the positive evidence in favor of their presence by such men as Dubois, Klek, Veit, Löwenstein, Von Preuschen, and others, negative evidence goes

but a little way. Unfortunately the microscope and chemistry has helped us but little in deciding the origin of these cysts, and so we are forced to decide as best we may from our anatomical knowledge and from reasoning by analogy.

The treatment of these cysts has been as varied and anomalous as the theories as to their origin. Some of the different methods which have been adopted are:

1. Simple puncture or simple incision.
2. Puncture or incision followed by the injection of irritants.
3. Excision of a part or whole of the cyst wall and application of irritants.
4. Removal of all that part of the cyst that projects above the vaginal surface, and suturing the mucous membrane of the vaginal to the membranous lining of the cyst.
5. Complete enucleation.

If the cyst be of any size, the first three methods are uncertain and unsurgical. Johnston, in his paper already alluded to, pronounces enucleation difficult and sometimes dangerous, and, together with Duncan, thinks it an example of surgical greed. He decides for the fourth method, as by all odds the best. In this I cannot agree with him. If the cyst be of moderate size, as in the case I have reported; and as most of them are, enucleation is the most surgical procedure and by no means presents the difficulties he would have us believe. A surgeon need not fear the little blood lost, and unless he be unskillful or clumsy, need not open the cyst. To have caused a fatal peritonitis, as happened in one of the cases reported by Johnston, some very primitive work must have been done. The cutting away of the cyst wall and stitching the mucous membranes together may probably be the operation of choice in some few cases, but a clean enucleation is the operation *par excellence* for most of them.

EYE-WASH.—A safe, cheap and good eye-wash can be made by putting one drachm of the crystals of boracic acid into one pint of soft boiled water; keep in a cool place, and bathe the eyes with three or four tablespoonfuls of the medicated water, as hot as can be endured, three or four times a day, letting some of the fluid get into the affected eye each time. The above is applicable in almost every case of inflammation of the conjunctiva, acute, subacute or chronic.

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CREMATION.

WHAT IS THOUGHT OF IT BY PHYSICIANS.

INTERVIEWS WITH PHYSICIANS BY A REPRESENTATIVE OF THE MEDICAL AND SURGICAL REPORTER.

NINTH SERIES.—WASHINGTON.

DR. I. W. BLACKBURN is in favor of cremation as a general method of disposing of the dead, from any point of view. Anything he might say in its favor could add nothing to its well-recognized desirability among members of the medical profession; though with his acquaintance with the horrors of decomposition, he might give some points to the laity.

DR. J. WESLEY BOVEE is very much in favor of cremation and particularly as a hygienic measure. It will tend to prevent the spread of diseases and save much land near large cities that would be used for cemeteries under the existing method of burial, and that will be needed for extension of the rapidly growing cities. It will also tend to lessen the fear of violation of bodies after burial.

DR. ROBERT T. EDES is of the opinion that in the present dearth of anatomical material in the District of Columbia, cremation would be a shocking waste.

DR. C. W. FRANZONI states that his personal prejudice is fast yielding to the necessities which are so rapidly forcing themselves upon us, and thinks that before another decade cremation will be an accomplished fact.

DR. W. W. GODDING expressed his views briefly in the following terms: Our quickest way back to the original elements, as well as the safest from a sanitary standpoint, is by fire. Interments in cities should be forbidden by law as dangerous to health. Rural cemeteries in suitable soils, with proper regulations, are safe enough, and sentiment is decidedly in their favor. Personally I had as lief be cremated as humated, but if my friends have any feeling about it I hope science will not forbid me the disinfecting by dry earth and the alchemy of the daisies.

DR. D. R. HAGNER had not thought sufficiently on the subject of cremation to

come to any decided expression of opinion as to its propriety, but as far as hygienic considerations are concerned there is no doubt in his mind as to its desirability.

DR. W. A. HAMMOND is entirely in favor of the cremation of the bodies of the dead, and has been for many years, but has no time to give his views in detail on the subject.

DR. W. H. HAWKES thinks that a reform in the present very unsanitary method of disposing of the dead, especially in large cities, is imperatively demanded, but confesses, however, to a prejudice against cremation. He favors the "New Mausoleum" plan, invented and perfected by a resident of Washington. Proposing, as it does, a gradual desiccation of human bodies with a destruction of the resulting gases and fluids, it seems to him thoroughly scientific in its details, sanitary in its results, and free from the objections, medico-legal and sentimental, which have been urged against cremation.

DR. A. A. HOEHLING writes: I am thoroughly in accord with those who favor cremation as the only proper method of disposing of the dead.

DR. JAMES KERR thinks that the sanitary objections against burial have been much exaggerated, and the traditions and sentiment of the human race is so much opposed to any other method for disposal of the dead that he is of the opinion that cremation, at present, is not within the possibilities of practical reform.

DR. A. F. A. KING thinks there is so much to be said on the side of cremation as compared with our present system of burials, that it is impossible to condense it into any brief expression, such as is here requested. The only objection he can see to cremation is the waste of "anatomical material," but if buried, it is generally wasted anyhow.

DR. W. LEE, Professor of Physiology in Columbia University, expressed his views as follows, when asked his opinion in brief on the propriety and desirability of cremation: Most unquestionably I favor it from both standpoints, as the result of my physiological training and experience as a medical practitioner, which both confirm prejudices in its favor from early life. I take it that you do not desire me to argue the question after it has been so ably dealt with by others. I can see but one valid objection, that of the jurist, regarding identification and the detection of crime; these I believe can, by

proper precautions, be reduced to a minimum which would be far overruled by the great sanitary benefit of cremation itself. We have every reason to hope that enlightenment and time will overcome that blind faith in ancient church rites which still obstructs the advance of this mode of the disposal of the dead; so that we can leave to the mussulman his grave made so hollow that he can rise upon his knees, with the same smile that we give to the account of Periander's wife who was so cold in hell for the want of the warmth of a funeral pyre. I know from personal inspection that the rites of cremation can be made as æsthetic and soothing to the mourner as the rites of burial in the church of to-day.

DR. LOUIS MACKALL, of Georgetown, regrets his inability to comply with the request to furnish his opinion as to the propriety and desirability of cremation, simply because he does not feel qualified to do so, not having given the subject the examination and due consideration that its importance demands.

DR. WM. MAY had no hesitation in saying that he considers cremation in every way the most desirable method of disposing of the dead.

According to DR. S. O. RICHEY, the burial of a dead body is tolerable only because it is a custom. It may not be a final disposition of the body, which may be stolen; or, in the march of improvements it may be disinterred, affecting the health of the community and violating the feelings of surviving friends. Besides, the sight of cemeteries is not cheering. Its only advantage is that it furnishes anatomical material not allowed by law. Cremation is desirable from a practical and hygienic standpoint. It is final. Opposition to it is a sentimentality, and will grow less as the thought and frequency of it become habitual.

DR. IRVING C. ROSSE, speaking at random and aside from traditional or sentimental considerations, can see no good reason, either from an economic or a scientific point of view, why this method of disposal of the dead should have preference over that usually employed by civilized people. To his mind, the subject is a concept that smacks of fetichism and other pre-historic usages that have disappeared since the advent of Christianity. He is aware that cremation has been defended with conviction by its priests and apostles, and he may even say it has had its martyrs; but there seems to be little

foundation for the arguments advanced by the partisans, and the only special cases in which it would seem obligatory are the circumstances of war and pestilence. However useful and desirable it may seem on the battlefield or in time of a grave epidemic, it is doubtful whether cremation can be encouraged as a question of social hygiene without interfering with certain religious opinions respecting the repose of the dead, and any effort on the part of the public power to prescribe the last duties to the dead would be a violation of the principle of liberty of opinion. He therefore questions the propriety and desirability of cremation as a general method of disposing of the dead, and it seems to him that in the present state of our social development the adoption of a habit so at variance with general custom will be sanctioned by only a feeble majority.

DR. CHAS. H. STOWELL, late of Ann Arbor University, is in favor of cremation for the following reasons:

First. The observations of Darwin, made fifty years ago, on the formation of molds, showed how the deeper soil could be brought to the surface, taking with it any specific germs it might contain.

Second. Pasteur showed that the germs buried for years at a depth of seven feet, with no disturbance of the surface earth during that time, may appear on the surface, and may even be blown over the surrounding grasses.

Third. It can pollute neither the earth, nor the air, nor the water.

Fourth. The exposure of friends at the grave, during the burial services, would be prevented.

He is opposed to it for the following reasons:

First. The amount of sickness caused by cemeteries is very slight.

Second. The exposure of friends at the grave is easily prevented.

Third. It lessens the chances of detecting murders.

Fourth. There is neither demand nor necessity for such a change from long established customs.

Fifth. The sentimental reason that cremation appears to do violence to the remains of the dead.

DR. J. FORD THOMPSON, when asked to give his opinions upon the subject, said that since cremation was brought forward as a method of disposing of the dead, he had

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been firmly convinced that it possesses, in several respects, advantages over burial; and he believes it will, in time, be very generally adopted by civilized communities.

Dr. J. L. WORTMAN, writes: It appears to be a well-recognized fact among medical men that decaying organic materials are conducive to the production of disease through the influence of micro-organisms. By our present system of disposing of the dead these microscopic organisms not infrequently contaminate not only the air we breathe, but the water we drink, and are doubtless often responsible for the outbreak of disease. It seems to me that in cremation we have the quickest, cheapest and most effective method of disposing of such offensive and dangerous materials. No sentiment for the dead should, in my opinion, interfere with our duty to the living.

Dr. H. C. YARROW is strongly in favor of cremation not only from sanitary reasons, but because of sentimental ones as well. It seems to him inconceivable that loved ones, cherished with tenderest care during life, should be carried off and deposited in the ground, there to become objects so hideous that the mere thought is terrible; not only this, but to serve as a source of pollution to water and a constant menace to the living. He does not like, for instance, the percolated water which flows possibly over the bones of his ancestors in Laurel Hill, Philadelphia.

be observed by him in his practice. Should he neglect to fulfill this duty, he is liable to a fine of one hundred ducats, and in case that he should be punished again, he would be condemned, without appeal, to banishment for a period of ten years.

"Poor patients, after the diagnosis of the pulmonary disease has been made, are brought immediately to the hospital.

"The manager of the hospital must give orders that all the patients' linen and clothes are to be kept separate from others.

"The police authorities must renew or clean the room which was occupied by the patient; the floor, bed-clothes and curtains as well as the windows and doors are to be destroyed by fire and replaced by others.

"Severe punishment will be inflicted upon those who will buy or sell clothes having belonged to phthisical patients."

Any house in which a patient died from phthisis was quarantined, and the proprietor lost all chance of letting his dwelling.

This law was also applied in Portugal. In Naples it was observed until the year 1848, but no decrease in the number of cases of phthisis was observed.

Professor Sée also presented another document, a letter written to him by Dr. Cornet, from Rouen, on the subject of the transmission of tuberculosis. The author of the letter thinks that the phthisical patient, personally, is not a dangerous medium, but that he creates danger by not spitting in the spittoon reserved for him. He thinks that the population of a place ought to be taught "never to spit in a handkerchief or on the ground, but always and only in a spittoon which must continuously be kept in a moist condition and never allowed to dry up."

In a practical point of view, the question of heredity need not be taken into consideration, as the nature of this predisposition is a very questionable point.

Professor Sée then continued that the real source of infection was the sputum and not the air, as is proven by many observations. For instance, it would be a difficult matter to find out one single case of tuberculosis which had occurred in a children's hospital, and this for one capital reason. The children do not spit, hence no sputum dust can be found in the air; except, of course, in surgical wards, where the pus from external tubercular lesions might become dry, and then be disseminated in the form of minute particles throughout the room or ward.

FOREIGN CORRESPONDENCE.

LETTER FROM PARIS.

Prophylactic Measures against Tuberculosis.
—Tracheal Injection of Naphthol in Pneumonia.—Ocular Complications of Influenza.—Removal of all the Bones of the Face for Osteo-fibroma due to Misplaced Teeth.—Treatment of Urinary Fistula Consecutive to Nephrotomy.

PARIS, Jan. 24, 1890.

At the meeting of the Academy of Medicine, Jan. 7, Professor Germain Sée produced a very interesting document. It was a police order about a hundred years old; which was promulgated at that time by the King of Naples. It read as follows:

"Any practicing medical man is compelled to communicate to the authorities of the country, any case of phthisis that may

Dr. Sée finally remarked that when a physician is brought before a man, a patient, suffering from tuberculosis, he had better not say that he has found any tubercular lesions in the patient, but recommend to him to be excessively clean, and to eat as much fatty food as possible, cod-liver oil, etc., for if a tubercular patient increases in weight his chances of being cured are very much increased.

Dr. Pignol has treated, in his medical dispensary of the Hôtel Dieu, three cases of pneumonia by tracheal injections of naphthol. The cases included one of double pneumonia, one of total right pneumonia in a tuberculous patient, and one total pneumonia in a non-tuberculous patient. The solution used was one of 20 centigrammes of naphthol for a 1000 cub. centim. In one from 200 to 350 cub. centim. of the solution are injected. A tuberculous patient suffering from a double pneumonia, received four injections, while the others only received one. These injections seem to be very well tolerated by the patient and produce no functional disturbance; on the contrary, the patient immediately feels a relief from his dyspnoea, and gradually one is able to find râles where only the bronchial noise had been perceptible.

In one case, the fever immediately came down after the injection—it was the beginning of the disease; in the others, there was an unmistakably favorable change.

Professor Duval remarked that the absorption by the bronchial mucous membrane has been used previously by Dr. Jousset de Bellesne, who, in cases of intermittent fever and malaria, where active measures were demanded, injected a solution of sulphate of quinine into the trachea, while he, Dr. Duval, has also demonstrated that water is so rapidly absorbed on the surface of the bronchial mucous membrane that in rabbits which have been asphyxiated by dipping the ends of their noses into water, all the blood corpuscles are immediately dissolved.

Professor Landolt, of the Paris Faculty of Medicine, has observed, during the present epidemic of influenza, several complications affecting the eyes. The most frequent complication observed was conjunctivitis, which is easily accounted for by the continuation of the nasal with the ocular mucous membrane and the easy way of the propagation of the inflammation of one of these surfaces to the other. The conjunctivitis which is most frequently observed is a special one,

and affects the palpebral mucous membrane as well as that of the eyeball. The eyeball is more injected than in simple catarrhal conjunctivitis, especially more violet in hue, darker, which indicates an extension of the disease in a deeper direction, involving the superficial layers of the sclerotic. The functional symptoms observed have been a severe photophobia, watering of the eyes, an increase of the lachrymal secretion and sometimes a muco-purulent discharge.

In certain cases, however, this conjunctivitis takes the form of a true episcleritis with localized deep injection of the sclerotic, presenting very painful symptoms, with an extension of the neuralgia to the eyebrows, forehead and temples. If the affection is only a conjunctivitis, in fifteen days the trouble will be over; if, however, it has extended to the sclerotic coat, a much longer treatment becomes necessary.

Another interesting ocular manifestation of this epidemic is the oedema of the eyelids, the latter being more or less swollen. When moderately developed it coincides with conjunctivitis, and gives to that form a special character. Still, one can observe it absolutely alone and strictly localized to the eyelids. This oedema usually occurs during convalescence. The eyelids very suddenly, during the night, become swollen, and when the patient awakes he finds that his eye is completely closed; at the level of this oedema a rosy-white coloration can be observed, but never redness. This oedema is very different from the erysipelatous kind, and with the finger one is enabled to produce a depression, which shows that the pathological process does not involve the derma. This oedema is painless, and disappears in about fifteen days.

Abscess of the upper eyelid is another accident observed; the abscess appears when the symptoms of the disease have vanished, several weeks even after the cure. The fever begins over again, painful pulsations occur on a level with the affected lid, accompanied by a very intense headache and sleeplessness. Soon the whole upper eyelid becomes tumified, and to such an extent that the region of the temple and cilia are involved; the skin presents a deep red discoloration, which might be mistaken for erysipelas, if fluctuation was not present to indicate the presence of a purulent accumulation. The incision must be made very deeply and the pus is found to have a remarkably bad odor. All these complications are benign in

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character and easily treated—for conjunctivitis, a warm boric acid solution, cold compresses for simple œdema; as to the abscess an early opening, followed by drainage, is indicated.

Dr. Péan presented before the Académie de Médecine a case of total excision of the facial bones for multiple osseous tumors of the bones of the face. The patient was a woman 32 years of age, in whom the sphenoid, the two maxillary and the malar bones were invaded by an osteo-fibroma, due to odontoma. The affection dated nine years. In 1884, a surgeon resected the right superior maxillary, but the disease soon recurred in the corresponding bone on the left side. Dr. Péan saw this patient for the first time in November, 1888; at that time the face was hideous to look upon: the left superior maxillary had the size of a new-born child, the inferior maxillary was tumefied; the cheeks, eyelids and nose were pushed out; the buccal, orbital, nasal and pharyngo-nasal cavities were obstructed, the alveolar borders were thickened and the teeth were movable and displaced without allowing one to suppose that two of the teeth were missing by ectopia.

On Dec. 14, 1888, he performed the first operation: the anterior surface of the maxillary bone was exposed by Dr. Péan's method; the patient was placed in the dorsal position, with her body and neck elevated; sponges were kept in the back part of the mouth; the cheeks, nose and septum were pinched previous to operating; then a median section of the upper lip is made, as well as of the dorsum and root of the nose. The cheeks were then detached from their mouth attachment with the knife and scissors. As soon as the tumors were exposed their prominent surfaces were excised with a knife having a concave blade. The other portions of the tumor were removed with cutting forceps. During this part of the operation the superior maxillaries, the malar bones, the pterygoid processes, the naso-orbital septum and the floor of the orbit were all rapidly removed. At this moment it was found that the superior lobe of the tumor had engaged itself under the inferior compact part of the sphenoid bone, which was excised, and to the operator's great astonishment a little molar or bicuspid, placed transversely in the spongy portion of the bone, was found.

This led to the supposition that this dental heterotopia had been the cause of the tumor, which was enucleated. Such an anomaly

is almost unique in man; in animals, the horse in particular, such heterotopic odontoma are of somewhat frequent occurrence.

Six weeks later, a second operation was performed to extirpate the inferior maxillary, by sectioning the soft parts from one angle to the other on a level with its inferior border, and dissection of the periosteum and of the tumor on both sides of the bone, together with bilateral section of the ascending rami and removal by pieces of the tumor which occupies the totality of the bone. The operation was completed by detaching from the symphysis the muscles which are there inserted, and cutting in the median line, the periosteum, which covers its inferior border. At this point a canine tooth was found placed in a transverse direction. This heterotopia is so much more interesting, as the teeth of the lower maxillary were complete in number.

The operation was a success; union by first intention took place, and after fourteen months there is no sign of the return of the trouble. Experience has demonstrated that tumors of this kind are extensively removed, as in the present instance, although there may be sarcomatous or myeloplaxic elements disseminated throughout the lamella and osseous fibrous tissue which compose it, they have very little tendency to recur.

Finally the author came to the following conclusions:

First. The total removal of the bony skeleton of the face can be successfully performed.

Second. Such an operation is indicated in cases of osteo-fibroma having for their origin dental heterotopia, when these tumors occupy simultaneously both maxillaries. In such cases a permanent cure can be looked forward to.

Third. The deformation and functional troubles produced by it, can be easily corrected by prosthetic dentistry.

At the last meeting of the Society, Dr. Tuffier reported a new cure for fistulæ, consecutive to nephrotomy. The method originated as follows: a man was admitted in the hospital wards of Prof. Guyon, the urinary specialist, complaining of renal and vesical pains, which he had experienced for a long time; on examination it was found that a calculus was present in the bladder, the patient was then subjected to several sittings of lithotripsy, stone crushing.

The immediate results were good, but soon a very intense pain appeared in the right lumbar region, while the general state

of the patient became very alarming, and it was then thought certain that serious renal complications had occurred. On July 13, nephrotomy was performed. No renal purulent abscess was found, but the pelvis of the kidney was filled with uric acid calculi, which were removed; no pyelonephritis existed; one portion of the incision was sutured, and a drainage-tube was kept in communication with the pelvis.

Cure was obtained without accidents, except the persistency of a urinary fistula. Injections of tincture of iodine into the fistulous tract were resorted to, and iodine was found in the urine, which proved that the ureter had remained permeable; on the other hand, the renal lesion had remained aseptic. The opposite kidney, it must be said, was strongly suspected; under such conditions, nephrectomy could not be recommended, and the fistula left to itself. Dr. Tuffier thought otherwise; the whole fistulous tract was exposed, the thickened portions were excised, and particularly the intra-renal fistula, and the raw surfaces were then sutured together; the operation proved to be a complete success.

This operation, however, could not be applied in every case, as it requires the existence of a permeable ureter and also an aseptic condition of the kidney. If nephrotomy is practiced on an aseptic calculous kidney, it will be easy to make it followed by a suture of the divided perenchyma through the operation. In such cases, the fistula will rarely occur.

Fistulæ are much more frequent in cases of suppuration of the kidney, or pyelonephritis; septic fistulæ are the ones that necessitate nephrotomy, and in that case, if the ureter is hardly permeable, the aseptic condition of the renal sac is very difficult to obtain, hence Dr. Tuffier's operation would not be very successful; and it would only succeed if the renal lesion could be rendered aseptic; still it is certainly a true fact that the paring of the edges of a renal fistula, followed by a suture, can be followed by successful results.

NEW YORK HAS 574.88 miles of streets to clean, and there are collected half a million cubic yards of street-sweepings and one and one-half million cubic yards of garbage and refuse yearly, at an annual cost of about one million dollars.

PERISCOPE.

Antipyretics in High Fever.

Dr. H. P. Wenzel, in an article dealing with the value of antipyretics in high fever, in the *Virginia Med. Monthly*, Jan., 1890, concludes as follows:

1. High fever, *per se*, is not inimical to life, but destructive to foreign organisms in the system.

2. High fever caused by pus, sanies, or detritus, etc., cannot be influenced by antipyretics; but promptly yields as soon as the pus, etc., is removed, and the parts are kept aseptic afterwards.

3. The pyrexia of cyclical or self-limited diseases is but little influenced by antipyretics.

4. In cholera, cholera morbus, and in all septic conditions of the alimentary tract, antipyretics are useless. Antiseptics are required notwithstanding the high fever. Typhoid fever is no exception to this rule.

5. In the exanthemata, pyrexia falls when the eruption appears irrespective of administered antipyretics, and in non-surgical acute brain diseases they are worse than useless.

6. In the diseases of infancy and childhood, careful attention, supervision of the diet, baths, and an aseptic condition of the digestive tube—in other words, common sense treatment—will be followed by better results than with the unlimited use of antipyretics.

7. Antipyretics frequently fail to reduce pyrexia; their use has in many instances caused increased pyrexia, collapse, and in some cases, death.

8. There is no pure antipyretic, all being also endowed with anodyne, analgesic, tonic, and other properties; hence,

9. It is impossible to estimate their antipyretic power or value.

10. Many remedies, although not classed generally as antipyretics, reduce temperature in fever indirectly.

11. Quinine causes protoplasmic shrinking.

12. The aniline derivatives reduce pyrexia at the expense of the blood.

13. The expectant plan of treatment plus sponge baths, is followed by better results than the unlimited uses of antipyretics, and the damage to the system much less.

14. Enterprising chemists invent drugs, and dictate to the medical profession for

what they shall be used; the medical profession should awaken to the importance of its dignity.

Syphilis of the Spinal Cord.

At the last meeting of the Society for Psychiatry and Nerve Diseases, of Berlin, Dr. Siemerling gave an address on the clinical and anatomical aspects of syphilis of the spinal cord, based on the careful observation of three cases. The first was that of a woman, aged 47, an excessive drinker. She had undergone several courses of treatment of syphilis by injection. She was first attacked with paralysis of the lower limbs. The patellar reflex was diminished. Disturbance of sensibility was so far present that the sense of pain was diminished on the left thigh, with slower conduction of sensation. The electrical examination revealed nothing. She had incontinence of urine and feces. The knee-phenomenon was peculiar; sometimes one knee was better and the other worse, and sometimes the order was reversed. Transverse myelitis of the dorsal part of the cord was diagnosed. The autopsy revealed considerable thickening in the pia of the dorsal portion. From this thickened pia a rather large cell infiltration passed over the substance of the cord, reached the anterior horn, passed through this, whereby the ganglionic cells disappeared. The tumor appeared to consist of true granulation tissue. In the surrounding parts was a myelitis of the nerve fibres.

The second case was that of a woman, aged 65. It was not determined when she became infected. In 1878 she had secondary symptoms, and underwent an inunction cure. In 1882 she had double vision, and in Dec., 1887, paresis of the legs. Later in the month she had a right-sided apoplectic attack, which disappeared in a few days without leaving any marked mental trace. In Jan., 1889, was admitted into the Charité with dementia, irritability, right-sided facial paralysis, left paresis of the lower limb, reflex immobility of the right pupil, left ophthalmoplegia externa and interna, bilateral exaggerated knee-jerk. Condition of sensibility negative. Section revealed a softening centre in the left corpus striatum and lenticular nucleus, gummata in the nucleus and left thalamus opticus. In the spinal cord was degeneration of the posterior column, arising in gummatous tumors in the

lower dorsal portion, and descending degeneration of the lateral tracts.

In the third patient, female, aged 42; the period of infection was unknown. Antisyphilitic treatment had not been systematic. Her way of life had been very poor. In March, 1887, she had paralysis of the left side of the body, with rapid improvement. Again in July, 1887, which was longer in passing off. In January, 1888, several attacks, in February another, with loss of consciousness, from which recovery quickly took place. Admitted into hospital on account of general weakness a month later. There was then dementia, left hemiplegia. Knee-jerk had disappeared. Improvement under antisyphilitic treatment. Later she had repeated apoplectic and epileptic attacks, of the latter as many as eighteen in a day. She afterwards became worse. The autopsy revealed softening of nearly the whole of the left hemisphere. Encephalitis. A large number of hemorrhages in the corpora quadrigemina. In the medulla left-sided descending degeneration, also of the right anterior pyramidal tract. The chiasma was full of infiltration. In the spinal cord the condition was more extensive than in the two preceding cases. The pia was everywhere thickened and infiltrated; from this bands passed into the substance of the cord, often into the gray substance, completely destroying the structure. The pia was firmly adherent at these parts. In the lower portion enormous growths as far as the anterior cornu. Right descending degeneration in the external pyramidal tracts, in the anterior commissure, etc. The vessels, both arteries and veins, were changed. The endothelium was destroyed by clots, the adventitia infiltrated, etc.—*Medical Press and Circular*.

Etiology and Treatment of Blepharospasm.

In an essay on this subject, in the *Archives d'Ophthalmologie*, Dr. Valude points out that blepharospasm of nervous origin, not preceded by traumatism and unaccompanied by any irritation of the external parts of the eye, is an obscure phenomenon, and has by different authors been regarded as of a reflex nature and as allied to hysteria. He proceeds to show that in one class of cases it is associated with ocular lesions, and caused by photophobic conditions that are dependent upon phlyctenular

keratitis and occur in scrofulous children. For this he agrees with M. Gayet in adopting forcible extension of the orbicularis palpebrarum muscle, and with Abadie in employing massage of the muscle with vaseline, traction being made chiefly in a radiating direction. Of course the treatment in general use for the primary disease must be practiced in addition. The second form of blepharospasm corresponds to those cases which are associated with troubles of the duct or cicatrices of the skin, on the one hand, and to hysterical, psychically degenerated and monomaniacal patients, of which he gives an instance, on the other hand. The treatment appropriate to such cases should be carried out. He refers to a case reported by Faus in which good results were obtained by the injection of a solution of curara of the strength of 1 to 100, thirteen drops being injected three times daily. It is remarkable that in this essay no notice is taken of the influence of hypermetropia and astigmatism in inducing blepharospasm. Some cases at least can be cured by the use of appropriate glasses.—*The Practitioner*, Jan., 1890.

Contagious Pneumonia.

Dr. F. Mosler, in a paper read before the Greifswald Medical Society, gives details of a series of cases of acute pneumonia in a family where there seemed every reason for believing that contagion was the cause of the spread of the disease. The patients were all attacked during the last fortnight of January, 1889, the first to fall ill being the father, who died on Jan. 22, the fifth day of his illness. On this day his wife was attacked, and she too succumbed on the fifth day of the disease. Whilst she was ill, her son, who constantly visited his parents during their illness, himself was attacked on the 26th. He was 30 years of age, strong and temperate, but succumbed on the twelfth day of the attack. Further, his sister, who had come from Arendsee, near Stralsund, to be with her sick parents, and who stayed in their house from Jan. 22 to Jan. 26, was attacked at Arendsee on Jan. 29, and was admitted into the Greifswald Hospital. She alone recovered. Dr. Mosler points out that the parents' house was dry, the two rooms they inhabited were well ventilated and clean, and that there had been no illnesses in the house within the past five years. He thinks the father must have acquired his

pneumonia outside, and that the disease was communicated in turn to the members of his family by contagion through the sputa. In the case of the son a *post-mortem* examination showed that the form of pneumonia was not the typical one: it was more lobular, was accompanied by a hemorrhagic pleurisy, and by swelling of the spleen. Moreover, an examination by Professor Grawitz of some of the fluid withdrawn from the lung of the daughter during the height of the disease resulted in the discovery of bacilli resembling those of rabbit septicemia, but neither the pneumono-bacillus of Friedländer nor the pneumono-coccus of Fränkel was found. In the case of the son the blood from the heart yielded a similar micro-organism. Dr. Mosler thinks that such facts, as well as the peculiarities of the morbid anatomy of the latter case, suggest the occurrence of a special form of pulmonary inflammation, owning a cause different from that of the ordinary form. He sees in such cases a reason for believing that many varieties of poison may give rise to pneumonia. But the main lesson from the cases is that of contagiousness, and the need for the careful disposal and disinfection of the sputa, which he believes to have been the infective medium in these cases. He refers to recent contributions of Finkler and Cantani on infectivity of pneumonia, the latter recording some striking instances where the disease was more of the lobular than the lobar type.—*Lancet*, Jan. 25, 1890.

Salpingotomy in Cases of Closed Utero-Vaginal Canal.

G. Leopold gives the history of several cases of atresia of vagina. In one, after futile attempts to form a vagina, the left tube and both ovaries were removed with complete relief to symptoms. In two other cases of hematosalpinx with atresia, the incision of the closed vagina was successful. In a fourth case an enlarged rudimentary horn was taken for an ovarian tumor. Laparotomy showed the true nature of the case, but the tumor was not removed. Later the tube began to be enlarged from increased pressure at each menstrual period, and the pains became so severe that a second laparotomy was necessary at which the right tube and ovary were removed. The patient remained cured.

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vagina, Leopold advises incision and allowing the contents to drain slowly away. If hematometra exists, it is opened from the vagina. If the enlarged tubes do not disappear, or if they swell at the next menstruation, their early removal by laparotomy is indicated. If in the absence of the vagina, the attempt to reach the hematometra is unsuccessful, the hematosalpinx should either be punctured from the vagina, or removed by laparotomy.—*Boston Med. and Surg. Journal*, Feb. 6, 1890.

Hair Wash.

Dr. Liebreich, in the *Therapeutische Monatshefte*, Jan., 1890, speaks highly of the following hair wash:

R Spirit. etheris	f 3 ij
Tinct. benzoini	f 3 jss
Vanillini	gr. i
Heliotropini	gr. iij
Ol. geranii	mj

M. Sig: One tablespoonful of the wash should be rubbed into the hair, which is afterward well dried with a towel. If the hair become too dry, lanolin pomade should be used. The mixture must not be used near a flame.

Lactation during Menstruation.

Ever since the days of Hippocrates and Galen, the belief has obtained that perfect lactation was inconsistent with the return of the menses. In a paper recently read before the Royal Medical Society of Vienna, by Dr. Schlichter, the result of this belief is seriously called in question, and there seems good reason to conclude that the effect of menstruation on the milk is not necessarily detrimental. The author obtained a number of samples of milk furnished by menstruating nurses and analyzed them with the result of showing that, as a matter of fact, the relative portion of casein had undergone no diminution. The quantity of fat was variable, but the variations did not exceed those met with in non-menstruating lactation, and maximum occurred just as often during a menstrual period as after or before. On only one occasion did the proportion of the non-fatty constituents diminish to the extent of 1.5 per cent., and the proportion remained practically the same. He remarked that, in the cow, the advent of the menses does not produce any noteworthy variations in the quality of the milk. Taking

the results of the analyses as a whole, it was found that the variations in the quality of the milk before, during, and after menstruation were not as marked as in milk drawn at different hours of the day under ordinary circumstances. An examination of the infants, moreover, failed to demonstrate any constitutional disturbance or failure of nutrition provided the menses did not return earlier than the sixth week. Although we are not prepared to endorse the very categorical conclusions of the author, it may be admitted that the occurrence of menstruation in nursing women is less hurtful than has generally been believed, but it is none the less a matter of clinical observation that their recurrence does diminish the quantity of the secretion, and may even cause it to cease at an earlier date. The supervention of pregnancy is under any circumstances a barrier to continued lactation, as much in the interest of the mother as in that of the child.—*Med. Press and Circular*, Jan. 22, 1890.

Mouth-Breathing and the Teeth.

Dr. Scanes Spicer read a paper at the last meeting of the Odontological Society of London, upon "Nasal Obstruction and Mouth-Breathing as Factors in the Etiology of Disorders of the Teeth." In the course of his remarks he said he had been struck with the frequency with which carious teeth were associated with obstruction of the pharynx and enlarged tonsils; so much so that he had made it a routine practice to examine the teeth in all cases of nasal obstruction, and he believed that there existed a relation between them; and he further is of opinion that there is a generic relation between some cases of vaulted arch, narrow jaws, and irregular teeth, and nasal obstruction. Normally we should breathe through the nose, so as to warm and filter the air respired. All animals, savage races, and young infants do so; but a large number of adults of civilized nations breathe through the mouth, because they have some obstruction of the nasal passages—erectile tumors, permanent catarrhal affections, polypi, post-nasal adenoid growths, etc. Mouth-breathing, he said, as a predisposing cause of caries of the teeth, came into action in various ways. The teeth were exposed to a current of air of a much lower temperature than that of the body, which would tend to cause in-

flammation of the periosteum and pulp of a tooth; the cold dry air produced congestion of the mucous membrane, with a secretion of stringy acid mucus; and the rapid evaporation of water which takes place when the mouth is constantly open inspissated this mucus, which so formed a fertile soil for the development of micro-organisms. Again, when sleeping with the mouth open, the tongue falls back and the parotid secretion finds its way directly through the pharynx instead of bathing and washing the teeth. With reference to the so-called V-shaped maxilla, Dr. Spicer thought that many cases might be traced to mouth-breathing, the muscles of the cheek pressing unduly upon the soft alveoli when the mouth is open.—*Lancet*, Jan. 8, 1890.

A Leech in the Larynx.

Prof. F. Massei, in an interesting article on foreign bodies in the air passages, in the *Archiv. di Laryngolog.*, reported among other noteworthy cases that of a man who had suffered since a fortnight with profuse hæmopteses. He came home exceedingly weak, and dated the beginning of his trouble from his swallowing some water from the water-casks of a vessel upon which he was sailing. At the laryngological examination a leech was found, attached to the right ary-epiglottidean ligament. It was at once removed, and the symptoms relieved.—*Intern. Journ. of Surgery*, Jan., 1890.

Menthol in Acute Rhinitis, and other Affections of the Throat and Nose.

According to the experience of Dr. Lennox Browne, of London, in the *Medical Press and Circular*, Jan. 8, 1890, the vapor of menthol checks, in a manner that is hardly less than marvelous, acute colds in the head, and is also to be recommended with a certainty of success, if used on its first onset, in arresting or as a preventive of infection in epidemic influenza, and this even for cases in which the nasal symptoms commonly associated with the word influenza are not manifested.

Menthol exerts its action in the following manner:

1. It stimulates to contraction the capillary blood-vessels of the passages of the nose

and throat, always dilated in the early stages of head cold and of influenza.

2. It arrests sneezing and rhinal flow.

3. It relieves, and indeed dissipates, pain and fulness of the head by its analgesic properties, so well known by its action when applied externally to the brow in cases of *tic douloureux*.

4. It is powerfully germicide and antiseptic. It thus kills the microbe of infection, and prevents its dissemination.

The remedy may be employed by means of a general impregnation of its vapor through a room or house, or locally to the nostrils and air passages; for both which purposes there are several methods.

First: A 10 to 20 per cent. solution of menthol in almond oil, in liquid vaseline, or in one of the many other odorless paraffin compounds, can be sprayed into the nose or throat, or about a room.

Second: By placing twenty or thirty grains in an apparatus specially designed by Rosenberg for administering the drug in cases of laryngeal consumption by inhalation, in the form of vapor mingled with steam.

Third: By placing a similar amount or one or two drachms of the oily solution in a Lee's steam draft inhaler, or bronchitis kettle.

Fourth: By placing a saucer of water containing a similar quantity of the crystals over a gas burner in the hall, by means of which the whole house is kept constantly permeated with the drug.

Fifth: But by far the most convenient method for personal use is to carry always the ingenious pocket menthol inhaler known as Cushman's, which should be used not only on the first approach of an attack, but three or four times a day during an epidemic, and always in cold-catching weather by those subject to head colds.

The instrument consists of a glass cylinder four inches in length, half an inch in diameter, and open at both ends. The tube contains crystals of menthol closely packed and prevented from escape by perforated zinc and cork. The opening at one end is twice the size of the other, the larger being intended for inhalation by the mouth the smaller for the nostril. It is not to be simply smelt, but well sniffed or inhaled, so as to cause some tingling or smarting, a sensation which is quickly followed by that of coolness, and openness of the previously "stuffed" and heated nostril.

Feb. 15, 1890.

Editorial.

211

THE MEDICAL AND SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

CHARLES W. DULLES, M.D.,

EDITOR AND PUBLISHER.

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Make communications as short as possible.

NEVER ROLL A MANUSCRIPT! Try to get an envelope or wrapper which will fit it.

When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.

The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

ASYLUM ABUSES.

From time to time we have referred in the REPORTER to accusations brought against asylums for the insane, most of which on investigation have proved to be utterly unfounded. Some of these charges, however, seem to have in them a sufficient basis of truth to require careful investigation. This was the case in regard to alleged ill-treatment of inmates of an asylum for the insane not long ago in one of the Western States, and a very serious charge has recently been made against the State asylums in New York. The first annual report of the State Commission in Lunacy for the State of New York was presented to the Legislature on January 29, and it contains some very serious charges against the management of these institutions. From this report it appears that on October 1 there were over fifteen

thousand persons in public and private insane asylums in the State of New York, with over five hundred idiots in the asylums provided for this class of sufferers. These are maintained at a cost of over one million dollars a year, which represents the expense of a number of institutions of varying degrees of efficiency.

As in most other States, it is complained that the asylums in New York are greatly overcrowded, and this, in that State, is charged to the fact that it is customary to admit private patients who pay good rates for their care and treatment, so as to exclude from the benefits of the State hospitals patients who are unable to pay in the same way. If this is a general custom, there can be no doubt in regard to the judgment of the community upon it as soon as it comes to be known; for no greater wrong can be conceived than that establishments intended for the benefit of the poor should be utilized for the treatment of individuals who might as well be cared for in institutions established for commercial reasons, and which cannot and will not treat those who are unable to pay their way. More than this, the admission of pay-patients in State asylums ought not to be permitted at all, because it introduces an element of temptation to the managers of those institutions, affording a way to make a good showing in the cost of their management by adding to their receipts the earnings derived from pay-patients. This is a temptation which would require a very high degree of virtue to resist, a somewhat higher degree than is supposed to reside in some managers of public and State asylums.

The report of the New York Commission on Lunacy points out "lamentable instances of squalor and neglect," and contains statements which are usually to be found only in the mouths of prejudiced relatives of the inmates of insane asylums, or newspapers given to exaggeration. This is a very serious matter, and it is to be hoped that the members of the profession in New York will interest

themselves in the subject, and either disprove these charges or take some steps to indicate their disapproval of what, if true, can only be designated as an outrage. It certainly seems time for something to be done when so respected a body charges that:

"In no one of these counties are the insane, in any proper sense, under the control of a medical officer. Only two have resident physicians. In only four or five are daily visits of a physician required by law. None of the superintendents of the poor or keepers are in the slightest sense qualified for their positions. Restraint upon patients is left to the discretion of untrained attendants. Patients are made to wallow all night in beds whose uncleanness defies description. It is a common practice to bathe several patients in the same water. This has been done in spite of the fact that most lunatics suffer from skin disease—many having loathsome ulcers. The ignorance of the keepers is shown by the fact that none of them seemed to disapprove of this shameful and horrible practice. In many instances the sexes are not separated properly, as is proved by the birth not long ago in one county poorhouse of a child having a lunatic father and an idiot mother."

The Commission believes that the environments of patients in the average county poorhouse would shortly produce lunacy in any sane person confined there. A large number of most shocking instances are related, which are of a nature too horrifying and filthy to be suitable for general publication.

These matters are of a sort which interest every member of the medical profession, as well as the members of the community. Medical men have no greater actual interest in them than the general community, but they are in a position to do more against abuses which exist, or to prevent the origin or spread of abuses where they have not been found. For this reason our readers will find it interesting to know what is going on in so important a State as New York,

and, perhaps, to inquire whether or not similar instances calling for investigation are occurring nearer their own homes.

HYPERTROPHIC ULCERS OF THE VULVA.

At a meeting of the New York Academy of Medicine, December 19, 1889, a most interesting pathological discussion was introduced by a paper, read by Dr. R. W. Taylor, in which he spoke of the manifestations of chronic inflammations, infiltrations, and ulcerations of the external genitals of the female, especially as bearing upon the use of the terms lupus and esthiomène of these parts.

Dr. Taylor was prompted to write the paper (which is published with beautiful illustrations in the *N. Y. Medical Journal*, Jan. 4, 1890) because of the confusion which had arisen in the study of these affections from the use of the term esthiomène, meaning a condition of the external female genitals similar to lupus of the face, first employed by Huguier about 1849, and repeated in all writings on the subject to a greater or less extent since that date.

The views entertained to-day in regard to simple infiltrations and hypertrophic and ulcerative lesions of the vulva is: 1, that they are identical with lupus, or the esthiomène of Huguier; 2, that they are the result of syphilitic processes; 3, that they are the result of some indeterminate ulcerative process; 4, that some may be the result of a tubercular infection.

Dr. Taylor's study of this subject began in 1870, in Charity Hospital, where there is a relatively large amount of material of this kind coming under observation, and he soon came to the conclusion that the subject would have to be studied anew, untrammelled by the older writings. The result of his investigation was the conclusion that perhaps the greater number of chronic deforming vulvar lesions are due to simple hyperplasia of the tissues induced by irritating

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causes, such as inflammations and traumatism; that chronic chancroid is a cause in a certain proportion of cases; that many cases are due to syphilitic infiltration; and that other cases are caused by hard œdema that often complicates and surrounds an initial lesion of syphilis. Many cases are due to simple hyperplasia in old syphilitic cases with local lesions, while some cases, also in old syphilitics, are due to hyperplasia resulting only in vulvitis.

The first class includes papillary growths, vegetations, and hyperplasias which occur singly or in numbers, chiefly around the urethral and vaginal orifices, but which are also found in the vulvo-anal region. Clinically and pathologically the larger growths are only exaggerations of the smaller. The smaller ones might well be called hypertrophied caruncles and simple hyperplastic tumors, varying in density and vascularity. Larger hyperplasias and vulvar hypertrophies of simple origin may arise from traumatism, vulvitis, vaginitis, gonorrhœa, or masturbation; their appearance varies greatly, and this is due largely to the difference in shape of the vulva in different women.

In justice to Dr. Grace Peckham, who also has investigated this subject, it must be stated that she has suggested that the name lupus or esthiomène be set aside, and in its stead the term hypertrophic ulcer of the vulva be used, prefixing, as the case may be, the adjective syphilitic, tubercular, or lupoid, where the diagnosis is possible.

This appears to be a correct term, although there is a difference of opinion in regard to the presence of evidences of tuberculosis in these ulcers. At any rate it is worth while to call attention to them in order that they may be subjected to wider and more thorough investigation. The readers of the REPORTER may have opportunity to add materially to the limited stock of knowledge on the subject now possessed by the profession, and to clear up what is still by no means as clear as it might be.

DANGERS OF CELLULOID.

A curious accident from the combustion of celluloid, reported in the *Bulletin Médical*, June 2, 1889, may serve to call attention to the dangers connected with its use in the household. It seems that a girl, wearing a hair-comb of celluloid, was working near a very hot fire, when all at once her head was seen to be enveloped in flames. These were promptly extinguished, but not until the child was severely burned. The circumstances of the accident were inquired into by M. Leon Faucher, and made the basis of an interesting report to the Council of Hygiene. From this report we gather that celluloid is made from gun-cotton, by treating the latter with alcohol, then mixing with it some camphor, and subjecting the whole to considerable pressure. The temperature at which combustion takes place is relatively low—about four hundred degrees Fahrenheit. Light celluloid, that is, celluloid to which no coloring matters have been added—ignites at about fifty or sixty degrees higher. As regards the character of the combustion, it is said to be almost instantaneous, and to be accompanied with no light.

The accident in the case referred to must be regarded as unique, especially in the method of its production; for while it is quite possible that a person wearing an article of celluloid might approach dangerously near an exposed gas-jet, or stoop carelessly over a lamp, it can happen but rarely that, with such an article on, he or she would be near a fire hot enough to ignite it. Faucher, indeed, has been unable to find any record of a similar case.

Celluloid is now used for making so many things designed for domestic or toilet use, such as knife and fork handles, combs, backs of hair-brushes and hand-mirrors—that it cannot be amiss to urge caution in bringing them near a fire, especially since several fatal accidents have been reported. A careless or ignorant house-maid—who is as likely as any one to have about her objects

made of celluloid, if only collars and cuffs—might be the means of inflicting great damage upon herself or others. Of course this class of persons cannot be reached through a medical journal, except very indirectly; but it would be well within the province of the family physician, in making his rounds and seeing articles of the kind described, to refer to the possible danger lurking in their use; and he could do this without either offending the intelligence of his patients or unduly exciting their fears.

TYPHUS FEVER AT NEW YORK.

The daily papers report that two cases of typhus fever have recently passed through Castle Garden, New York, one of the patients being a passenger from a Mediterranean port, who died Jan. 7, while the other came from Antwerp, and was in the hospital when this was written.

There seems to have been some unnecessary concern in regard to these cases, as witnessed by the fact that it is recorded that the men had communication with scores of other immigrants, and there was apprehension of others contracting the disease from them. There is so little real danger in the case that we trust we have now heard the last of it and that nothing will be done to exaggerate the alarm which the occurrence might easily give rise to.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

STUDENT AIDS SERIES, Volume IV. *Obstetrics*, by SAMUEL HALL, M. D., pp. 142. *Gynecology*, by ALFRED S. GUBB, M. D., pp. 76. New York: G. P. Putnam's Sons, 1889. Price, paper, 25 cents; cloth, 50 cents.

These allied subjects have been treated together in one small volume by their English teachers in a manner deserving of a better fate at the hands of the American publishers. "Obstetrics" is so poorly and finely printed that it may well be an aid to the study of myopia, rather than of obstetrics. The volume is without illustrations of any sort, when they would have aided greatly in elucidating the text. Of the

many compends on these subjects, this "Aid" is especially concise, clear and practical, and in spite of the ocular difficulties connected with the obstetric section, it will well repay careful reading and reference by the student.

LITERARY NOTES.

—Dr. William B. Atkinson is editing a Medical Directory and Intelligencer of the States of Pennsylvania and Delaware, which will be the eighth edition of what was formerly the *Philadelphia Medical Register and Directory*. The new Directory will contain lists of the profession, giving, as formerly, the place and date of graduation, office hours, and residence, as far as these can be obtained, for the city of Philadelphia, the States of Pennsylvania and Delaware, and the city of Camden and vicinity.

—Charles Scribner's Sons announce that they have acquired from Mr. Henry M. Stanley all the American rights for his personal narrative of the expedition for the relief of Emin Pasha. Prior to the appearance of the complete work, *Scribner's Magazine* will publish an article upon his last journey by Mr. Stanley. It will be illustrated and is certain to be as important a contribution as any that has ever appeared in an American magazine.

—E. B. Treat announces the early delivery of the 8th yearly issue of the *International Medical Annual* (for 1890). Its thirty-seven editors in the several departments are to give a summary of new remedies alphabetically arranged, also a *resume* of new treatment in dictionary form, with references to the medical literature of the world pertaining to the year's progress of medicine.

—Messrs. Johnson Brothers, of Denver, have purchased the *Denver Medical Times* and will publish it in future. Dr. Thomas H. Hawkins will still retain the editorial control of the journal.

CORRESPONDENCE.

Inversion of Uterus.

TO THE EDITOR.

Sir: The report of a case of inversion of the uterus by an acquaintance in South Carolina, which terminated fatally, recalls a case of this rare occurrence that came under my treatment several years ago, in which I had the fortune to be able to promptly reduce the inversion. I was then practicing medicine in West Newton, Pa.

I received a telegram from Dr. N. to come at once to his assistance, seven miles distant. I went by train within the hour, supposing I had a case of surgery, as often happened in the mining hamlet in which I was called. I was surprised and shocked when I found a case of inversion of the uterus. The woman, a German and a primipara, had a peculiar history: both her mother and maternal

grandmother first child she conceived everything after a gratulation making kneading when she rushed of placenta protruding hemorrhage. The patient rapid (ing hemorrhage, antenatally. vagina, tion with duce the Finding in my first the minutes turning, the sati the entire draw it. The patient loss of of the p complete learn w died of, formed, and the edge.

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grandmother had died in child-bed—with first child—in Germany, from what cause she could not tell. She had approached her confinement with great dread. Dr. N. said everything went well, the child was born after a moderate labor and all were congratulating themselves. The physician was making careful traction on the cord and kneading the womb gently through abdomen, when suddenly the placenta came with great rush of blood, and when he got blood and placenta away discovered the womb protruding from vagina. There was no further hemorrhage. I arrived two hours afterward. The patient was pallid, her pulse feeble and rapid (150); everything indicated exhausting hemorrhage. She had received stimulants, and I gave her morphia hypodermically. I found the fundus protruding from vagina, and at once began efforts at reduction without anesthesia. I tried to first reduce the fundus by applying my knuckles. Finding that unsuccessful, I grasped the mass in my hand and began attempting to reduce first the part last everted, and after several minutes I was gratified to find the parts returning, and in less than thirty minutes had the satisfaction of feeling my hand within the entirely restored womb. I did not withdraw it until I had vigorous contraction. The patient was so nearly unconscious from loss of blood that she complained but little of the pain of taxis. She made a slow but complete recovery. Dr. N. endeavored to learn what her mother and grandmother died of, but was never, as far as I was informed, successful. Dr. N. is now dead, and the case has passed out of my knowledge.

Yours truly,

T. H. PATTEN.

The Porro-Cæsarean Operation.

TO THE EDITOR.

Sir: Mr. Lawson Tait, in the *British Medical Journal* of Jan. 18, 1890, uses the following language: "How any proceeding comes to be called a 'Porro-Cæsarean operation' is to me inexplicable. Dr. Harris says I claim to have done three such. I claim nothing of the kind." "I have seven times amputated the pregnant uterus, and six of the patients are living." Then we are to infer that he did not open and evacuate the uterus—i.e., perform a Cæsarean section before the supra-vaginal amputation of the uterus and ovaries?

Professor Porro, in 1876, gave the following title to his operation: "*Utero-ovarian amputation as complete of the Cæsarean section.*" The following are the titles by which this operation has been called by other operators in Italy: "*Istero ovariectomy cesarea.*" "*Amputazione cesarea dell'utero.*" "*Amputazione cesarea utero-ovarica.*" "*Taglio cesareo metodo Porro.*" Dr. Heusner, of Barmen, Germany, operated on April 15, 1888, and reported the case as "*eine modification des Porroschen Kaiserschnittes*" (a modification of the Porro-Cæsarean section), the stump having been dropped in. Dr. Ulietti, of Bergamo, operated May 17, 1884, and June 4, 1885, and reported "*Due operazioni cesaree Porro.*" Dr. Paul Grossmann, of Omaha, operated on May 10, 1882, and reported the case in the *American Journal of the Medical Sciences*, October, 1883, p. 477, under the title, "*A modified Porro-Cæsarean operation.*" He also dropped in the stump.

If Mr. Tait thinks that the supra-vaginal amputation of the uterus is entirely dissociated from the Cæsarean part of the operation he will not find many to believe with him. According to his ruling, if a woman ruptures her uterus, and the dead child is removed by the knife from the abdominal cavity, a subsequent removal of the uterus would be a Porro operation. I protest against such a false classification as this, and loading the far less fatal operation of Professor Porro with such a death-rate of mothers and children. It was to avoid the improper use of the name of Porro that led me to adopt the compound title of Heusner, Grossmann, Ulietti and others, dating several years back. A "Porro operation" is a Porro-Cæsarean, and is erroneously called a Porro.

Yours truly,

ROBERT P. HARRIS, M. D.

329 S. 12th St., Philadelphia,
February 6, 1890.

SWEAT-BANDS IN HATS.—Sweat-bands of hats may contain even twenty-eight per cent. of fatty acids, which in summer may penetrate into the forehead and cause inflammation, and corrode deeply into the skin. Rub with burnt magnesia every little while, so as to leave a small film on the band; wipe it off with a cloth before applying again.

NOTES AND COMMENTS.

Long Fastings and Starvation.

The sensation of hunger is a painful feeling of uneasiness and weakness. It is a general feeling, but is localized apparently in the stomach. Many ancient authors regarded it as a local sensation. Some said that the gastric fluid became more acid and produced a burning feeling in the stomach; others, that a contraction of the stomach took place. But, although the sensation of hunger is related to the stomach, it is really general. While it is sometimes alleviated by swallowing earth and stones, such inert substances may deceive it, but do not appease it. It has, moreover, been experimentally determined that the feeling of hunger is not abolished after cutting the pneumogastric or sensitive nerve of the stomach. So, in thirst we feel a dryness in the back part of the throat. The local sensation is deceptive, for thirst does not depend upon any condition of the mucus of the pharynx. It is caused by the exhaustion of the watery elements of the blood. It is therefore removable by injections of water, and by bathing, when water is absorbed by the pores. If hunger is not satisfied, it disappears after a certain length of time. The most intense suffering is endured during the first twenty-four hours, after which the pain diminishes. The characteristic phenomenon exhibited by an animal subjected to starvation is the constant diminution of weight. Dr. Charles Richet has made many experiments on this loss, comparing animals of various sizes, and has determined that the function of dehydration—or reduction of weight—is in direct relation with the size of the animal. Carnivorous animals appear to bear fasting better than herbivorous kinds. The latter eat nearly all the time, and are ill when they have to stop; but carnivorous animals, in the wild state, are often forced to endure abstinences of considerable length; and a fast of several days is almost a physiological condition with them. When we examine the phases of the loss of weight of a starving animal, we find that it loses much during the first days. Then a moderate drain sets in. Again, in the last days considerable loss takes place, and this is the forerunner of death. Cold-blooded animals can support inanition during a prodigiously long time. M. Vaillant tells of a python weighing seventy kilogrammes that lived

twenty-three months without eating, and M. Colin of a rattlesnake that lived twenty-nine months. Redi mentions a tortoise that lived eighteen months, and a frog sixteen months, without food. Dogs can endure abstinence, on the average of thirty days; cold-blooded animals, twice as long. With both classes the fatal limit is reached when the loss of weight amounts to 40 per cent. This point is reached by the warm-blooded animal ten times as quickly as by the cold-blooded one. Man is subject to the same conditions in case of fasting or starvation as warm-blooded animals; and the influences of size, age, and nervous constitution are similar upon him. — *Revue Scientifique*; *Popular Science Monthly*, Feb., 1890.

Total Resection of Facial Bones.

At the last sitting of the Académie de Médecine, M. Péan introduced the subject of total resection of the bones of the face, and cited the case of a woman thirty-two years old, whose sphenoid, three maxillaries, and malar bones were invaded by an osteo-fibroma, which began to appear nine years previously. In 1884 the right superior maxillary was resected by one of his colleagues and four years subsequently the patient came under his notice. At this time the face was simply hideous to look upon; the left upper maxillary was the size of the head of a newly-born child, and the lower jaw was swelled considerably, the cheeks, eyelids, and nose were sunken, and the several cavities obstructed, so that mastication, phonation, and vision were much hindered. An operation was performed by making a median incision along the nose and through the upper lip, which permitted the detaching of the vestibule of the mouth and the cheeks with the bistourys, as soon as the tumors were brought to view and ablated successively. It was thus that the superior maxillaries, the malars, the pterygoid apophyses, and the floor of the orbits were rapidly removed. The upper lobe of the tumor was then perceived to be engaged under the sphenoid bone, and when the latter was resected a molar tooth was found embedded in the spongy tissue, which led to suppose that this tooth was the cause of the neoplasm. Six weeks subsequently the lower jaw was removed, and the result was favorable. The wounds healed by first intention, and no relapse took place. An

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apparatus ingeniously contrived permits the woman to speak, swallow, and retain her saliva. M. Péan concluded by saying that the result of the case above mentioned proved that total ablation of the bones of the face can be made with success, that the operation was indicated in neoplasms of the extent described, and that a relapse need not be feared.—*Med. Press and Circular*, Jan. 23, 1890.

Dobell's Solution.

In answer to the request of a subscriber, we quote the following from the *National Formulary*:

Dobell's solution, or compound solution of borate of sodium, has the following formula:

Borate of sodium	120 grains
Bicarbonate of sodium	120 "
Carbolic acid, crystallized	24 "
Glycerine	½ fluidounce.
Water, enough to make 16 fluidounces.	

Dissolve the salts in about eight fluidounces of water, then add the glycerine and carbolic acid, previously liquefied by warming, and, lastly, enough water to make sixteen fluidounces. Finally filter.

Fatal Alcoholic Poisoning.

Dr. MacFarlane has recently reported to the Allegheny County (Pa.) Medical Society a case of fatal poisoning by whiskey. A boy, aged 5 years, who was in poor health, while unobserved, drank from a bottle in the room he was in, six or eight ounces of whiskey. This occurred about noon. The child was put to bed to sleep the liquor off. After taking the whiskey the child became blanched and this was followed in an hour or so by purging and vomiting. About six o'clock the doctor saw the patient. He had a rapid pulse and a normal temperature. The pupils were dilated and did not respond to light. There was occasional twitching about the face and slight tremor about the hands and fingers. The breath of the patient had a distinct whiskey odor. Bromide of potassium and coffee were given. When seen again at eleven o'clock the child was in general convulsions, and died about half-past eleven, eleven hours from the time it took the liquor.—*Druggist's Circular*, Feb., 1890.

Plaster-of-Paris Splints.

Dr. Powell, of Toronto, recommends the following method of applying plaster-of-Paris splints for certain kinds of fractures of the leg. "The leg is to be bandaged with cotton batting, which for the purpose is torn into strips four inches wide and applied as a roller. Using the sound leg as a model, to save the injured one from movement, a pattern is cut which will cover in all of the leg excepting a space an inch wide along its anterior aspect. Deep slashes opposite the heel allow the part for the sole of the foot to be brought into a right angle with that for the leg, without forming clumsy folds at the ankle. From this pattern four or five layers of scrim, or from six to nine of cheese-cloth are cut. Then, with extension made and the foot properly held, the strips are to be saturated with a cream made by sifting, not stirring, plaster into warm water, smoothed one upon another, applied to the posterior aspect of the limb, interleaved by the slashes at the ankle so as to hold the foot at right angles with the leg, moulded to the part, and then firmly bandaged to it with a cotton roller." "Scrim" is a coarser and stronger material than cheese-cloth, and hence a smaller number of layers suffice to make a firm splint. This is a modification of the well-known Croft's splint, and it is recommended as very being easily applied, comfortable, durable, and thoroughly efficient.—*Lancet*, Jan. 25, 1890.

Preservation of Urine for Examination.

In order to arrive at the true condition of a sample of urine, the earlier it is examined the better. It is, however, sometimes impossible to obtain it for examination for many hours, or even days after it has been passed from the bladder, and, under ordinary circumstances, it is then entirely changed. Various substances have been recommended as anti-ferments and preservatives, but all have objectionable features. Accident recently led us to try naphthalin in this direction, and the results were as gratifying as they were unexpected. Though the substance is well nigh insoluble in water, and a crystal added to urine remains unattacked, so far as appearances go, for days, a very minute quantity of it sufficed to preserve a couple of ounces of urine apparently un-

changed for several days, in fact, during the warm weather of Christmas week.—*St. Louis Med. and Surg. Journal*, Feb., 1890.

The Prophylaxis of Tuberculosis.

The question of tuberculosis and its preventive treatment was brought up again at the Académie de Médecine by M. Lancereaux, who said that the conditions which gave rise to tuberculosis were the same as those which presided at the development of any other malady, and were of three orders: predisposing, efficient and determinating causes. As to the efficient cause, it is well known to-day it is the bacilli of Koch, but this even would not be sufficient if there did not exist a certain modification of the organism which is called a *predisposition*. Consequently it is necessary to understand the different circumstances which give rise to this predisposition in order to be able to pronounce on the most effective prophylactic measures. The savages never contract phthisis, and the Kirghis of the Russian steppes and the American Indians have never been attacked with the malady. Tuberculosis did not exist in America before the arrival of Europeans, but gradually it appeared in towns or wherever there was an agglomeration of individuals. What, then, are the causes which favor the development of tuberculosis? Amongst the many he would insist on two which appeared to him as the most exciting: *insufficiency of air and the abuse of alcoholic liquors*. In London the frequency of tuberculosis is in direct proportion to the number of inhabitants in a given space. The same may be said of Paris and every large city. Many authors have stated that in prisons, schools, etc., tuberculosis was very frequent, and also that individuals who have been accustomed to living in the open air, and who from different causes are submitted to inactivity and the influence of confined air, become rapidly phthisic. It is thus that young girls from the country coming to work in towns contracted first anemia and finally phthisis. Of 2,000 cases of tuberculous patients noted in the hospitals, 1,100 were belonging to the working classes living or working in small shops where the air was insufficiently renewed. As to the influence of alcoholism on the etiology of the malady, it was indisputable. For several years his attention was drawn to this subject, and he found that

drinkers of absinthe were particularly liable to contract the disease. He was able also to state that drunkards presented a pulmonary localization at the summit of the *right lung*, more developed behind than before, while in others the left lung was the most frequently attacked. Hæmoptysis is frequent amongst the former, while amongst those who contract the disease from other causes the granular form is predominant. M. Lancereaux, in conclusion, said that he did not consider the measures proposed by the Commission as sufficient. Certainly he advocated the destruction of the expectoration as advised, but much more was required. Above all it was necessary to make the authorities understand that pure air was indispensable to the life of man, and that legislation should be reformed as to the construction of houses, the widening of streets, and the proper control of workshops, barracks, colleges, prisons, etc., so that each individual should have his complement of cubic feet of air.—*Med. Press and Circular*, Jan. 22, 1890.

Mind Blindness.

Two cases in which this curious symptom was observed have recently been recorded in the *Archiv f. Psych.*, vol. xxi. In the first, recorded by Lissauer, a man of eighty had complained for a month of inability to find his way about, to tell his own position in a room, and to recognize objects, although his perception of light was scarcely impaired. Although he could not recognize objects by looking at them, he at once perceived and named them by means of tactile or auditory impressions from them. On examination he was found to have absolute right homonymous hemianopsia. He had some aphasia, and could not read, but he could write. Perception and discrimination of colors in this case were preserved. In the second case, recorded by Siemerling, the onset was sudden. At first visual memory only was impaired; but he soon failed to recognize objects, even when he touched, tasted, or heard them. On examination he was found to have absolute right homonymous hemianopsia, together with amblyopia in the left field in each eye. Color sense was lost on both sides. There was also amnesic aphasia. In this case very great improvement occurred, the amblyopia on the left side improved, and color vision returned. In neither case was there any change in the fundus. The asso-

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ciation of "mind blindness" with hemianopia, and occasionally with loss of color sense, has also been observed by Wilbrand, Charcot, Swanzy, and others. It is, however, very rare, while hemianopia is not uncommon; and Siemerling's case, where there was amblyopia in the left field, with complete loss of vision in the right, gives support to the hypothesis of Dr. Gowers that it occurs only when the cortical lesion is double.—*Lancet*, Jan. 25, 1890.

U. S. Army Examining Board.

An Army Medical Board will be in session in New York City, N. Y., from May 1 to 31, 1890, for the examination of candidates for appointment in the Medical Corps of the United States Army, to fill existing vacancies. Persons desiring to present themselves for examination by the Board will make application for the necessary invitation to the Secretary of War, before April 1, 1890, stating the place of birth, place and State of permanent residence, and enclosing certificates based on personal knowledge from at least two physicians of repute, as to professional standing, American citizenship, character and moral habits; also, statement of service in hospital from the authorities thereof is desirable. The candidate must be between 21 and 28 years of age, and a graduate of a *Regular Medical College*, as evidence of which, his diploma must be submitted to the Board.

Further information regarding the examinations and their nature may be obtained by addressing the Surgeon-General, U. S. Army, Washington, D. C.

Extra-Uterine Pregnancy.

In an article on the subject of extra-uterine pregnancy, referred to in the *New York Med. Journal*, Feb. 8, Dr. Lopez concludes as follows:

1. The physician should know how, whence and when fecundation is effected.
2. One should recognize in extra-uterine pregnancy the existence of the life of the fetus the same as in normal uterine pregnancy.
3. The only forms of extra-uterine pregnancy are abdominal and tubal.
4. With regard to the termination of embryonal development, whether in extra-uter-

ine pregnancy or in uterine pregnancy in which there has been rupture of the uterus and fall of the fetus into the abdominal cavity with unruptured membranes, if such pregnancy has continued to term, extraction should be performed by the appropriate operation.

5. If the fetus has died, whether in cases of extra-uterine pregnancy or in those in which there has been rupture of the uterus and fall of the fetus and membranes into the abdominal cavity, an appropriate operation for extraction should be performed.

6. No interference should be attempted as long as the fetus is living, unless eight months have passed since conception.

Alvarenga Prize.

The College of Physicians of Philadelphia will award the Alvarenga Prize, consisting of one year's income of the bequest of the late Señor Alvarenga and amounting to about two hundred dollars, to the author of the best memorial or unpublished work on any branch of medicine. The College reserves the right to reject all essays not considered worthy of the prize. Essays will be received until June 1, 1890, by the Secretary, Dr. Isaac Norris, Jr.

Paralysis from Compression of the Wrist.

The Berlin correspondent of the *Med. Press and Circular*, Jan. 29, 1890, speaks of a case of paralysis following arrest which was reported by Professor Eulenburg in the *Neurologische Centralblatt*:

In 1882 Bernhardt first drew attention to the fact that grasping of the arm as performed by police officers in the act of arrest, over the part where the radial nerve comes to the front was followed sometimes by paralysis of the hand. He reported some cases. Bernhardt, in consequence of his observations, made the suggestion that officers should grasp their charges immediately above the wrist. Professor Eulenburg's case shows that even grasping in this locality can be followed by evil consequences if the force used is sufficiently energetic. During a short walk of not more than three hundred yards the median nerve in this case suffered sufficient compression to produce paresis, implicating both sensory and motor functions.

Treatment of Angina Pectoris.

Dr. T. Frederick Pearse says, in the *Lancet*, Feb. 1, 1890, that of all the drugs that have been tried for this distressing complaint nothing comes up to the nitrite of amyl. In cases, however, where the attacks of pain occur very frequently, but are of a comparatively mild degree, the nitrite of sodium is more reliable and has a more lasting effect. Five-grain doses may be given without hesitation and repeated every four or six hours as may be necessary. Nitroglycerine, like nitrite of amyl, is more rapid in alleviating the symptoms, but similarly its influence is of shorter duration. Dr. Pearse thinks that the state of the patient's mind is relieved by combining small doses of morphia with the nitrite—at any rate, the combination has seemed to him a decided advantage. It has been his practice to keep a belladonna plaster over the left breast continuously for some weeks.

Treatment of Gonorrhœa in the Female.

The following formula is given in the *Journal de médecine de Paris*, Dec. 1, 1889:

R Creolini f 3 ss
Ext. hydrastis can. f 3 ijs
Aque f 3 vij

M. Sig. A dessertspoonful should be added to one pint of water and used for an injection.

Antipyrin Incompatible with Naphthol.

M. Chabrol, of Paris, states that on mixing betanaphthol, antipyrin and bismuth salicylate he found that a paste resulted. Experiments demonstrated that the reaction occurred between the antipyrin and the naphthol.

NEWS.

—Dr. H. Frey, formerly Professor of Histology in Zurich, is dead.

—A movement is on foot in San Francisco to establish a much needed ambulance service in that city.

—Dr. C. S. Ayres has been elected President of the Cincinnati Polyclinic Graduate School of Medicine.

—Sir William Withey Gull, physician-in-ordinary to the Prince of Wales, died in London, January 29.

—A survivor of the famous Shannon and Chesapeake fight died at Truro, N. S., on January 29, aged 106.

—A report has been received in Berlin that Dr. Karl Westphal has recently died in a private asylum at Constance.

—Dr. T. Gaillard Thomas has resigned the chair of Clinical Gynecology in the College of Physicians and Surgeons, New York.

—Perhaps the oldest woman in New York State died Jan. 26, at the age of 107 years and three months, at Warwick, Orange County.

—The epidemic of influenza is reported by 98 per cent. of the physicians reporting to the State Board of Health as still being prevalent in Michigan.

—During the week ending Jan. 25, there were 552 deaths in Philadelphia. Twenty-three of these were directly from the influenza and 238 from allied diseases.

—The Associated Charities of Denver, Col., have asked the County Commissioners for an appropriation of \$10,000 towards establishing a free hospital in Denver, for the care of the impoverished sick.

—During the week ending Jan. 25, one hundred and twenty-seven deaths in London were attributed to "la grippe." The mortality from diseases of the respiratory organs is still abnormally large in London.

—Professor Otto Madelung, of Rostock, has been appointed to succeed the late Professor Volkmann. Professor Madelung has made a specialty of intestinal and rhinoplastic operations and has taught surgery both at Bonn and Rostock for several years.

—A Weekly Rest Congress was recently held in Paris, under the presidency of M. Léon Say, the object of which was to urge the general observation of one day of rest in the seven, which is regarded by the members of the congress as necessary for the preservation of the health of man as well as of beast.

—Senator Ingalls has introduced a bill into the Senate establishing a Board of Medical Examiners for the District of Columbia. The bill provides that the Board shall consist of ten physicians or surgeons, three dental surgeons, and, in addition, five homœopathic practitioners of medicine. The term of office is to be four years.

—There are said to be over 200 helpless lunatics in the jails of Virginia who are suffering for want of proper care. No efforts are being made by the authorities to remedy this state of affairs, with the exception that the Legislature is considering the feasibility of transforming the colored normal school buildings at Petersburg into an asylum.

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